STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265307	A. Building B. Wing	12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire Senior Living Webb City	2077 Stadium Drive Webb City, MO 64870

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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 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training. Based on observation, interview, and record review, the facility failed to ensure nurse aides (NA) were not used more than four months without completing required training and evaluations when the facility did not have an effective process in place to ensure certified nurse aide (CNA) training programs were completed timely for NAs resulting in eleven NAs (NA Q, NA T, NA I, NA K, NA AA, NA B, NA W, NA S, NA R, NA C, and NA U) working longer than four months in the facility without completing the CNA training course. The facility census was 106.Review of facility policy titled, Hiring of Non-Certified Nurse Aides (Missouri), undated, showed the following:-Trainees must enroll in a Missouri-approved CNA program totaling 175 hours, which consist of 75 hours classroom instruction and 100 hours on-the-job clinical training;-Trainees must successfully complete the initial 16 hours of required training before any direct resident contact;-Trainees must pass the Missouri CNA exam within the required timeframe following course completion;-The facility may not permit trainees to continue working in resident care if they fail to meet certification timelines or exam requirements;-Trainees who do not complete training, fail exams, or demonstrate unsafe care practices must be removed from resident care and may be subject to termination. 1. Review of NA Q's personnel file showed the following:-Date of hire of 11/26/24 (one year and thirteen days prior);-Staff documented NA Q enrolled in the online nurse aide training program on 10/04/25;-Staff did not have documentation NA Q had completed the nurse aide training program. 2. Review of NA T's personnel file showed the following:-Date of hire of 01/15/25 (ten months and twenty-four days prior);-Staff documented NA T enrolled in the online nurse aide training program on 10/17/25;-Staff did not have documentation NA T had completed the nurse aide training program. During an interview on 12/09/25, at 12:35 P.M., NA T said he/she started the online CNA class in the middle of November. Staff can come into the facility Monday through Friday from 8:00 A.M. to 5:00 P.M. on their days off to work on the class. 3. Review of NA I's personnel file showed the following:-Date of hire of 01/15/25 (ten months and twenty-four days prior);-Staff documented NA I enrolled in the online nurse aide training program on 10/17/25;-Staff did not have documentation NA I had completed the nurse aide training program. 4. Review of NA K's personnel file showed the following:-Date of hire of 02/21/25 (nine months and eighteen days prior);-Staff documented NA K enrolled in the online nurse aide training program on 10/04/25;-Staff did not have documentation NA K had completed the nurse aide training program. 5. Review of NA AA's personnel file showed the following:-Date of hire of 03/06/25 (nine months and three day prior);-Staff documented NA AA completed the online nurse aide training program on 07/30/25, however failed the exam. During an interview on 12/05/25, at 11:47 A.M., NA AA said the following:-He/she was previously a CNA, however let his/her certification expire;-He/she watched 17 hours of videos and completed three days of on the job traning with a CNA;-He/she completed the nurse aide training program approximately four months ago, however failed the test. 6. Review of NA B's personnel file showed the following:-Date of hire of 03/12/25 (eight months and twenty-seven days prior);-Staff documented NA B enrolled in the online nurse aide training program on 10/04/25;-Staff did not have documentation NA B had completed the nurse aide training program. During an interview on 12/05/25, at 2:51 P.M., NA B said the following:-He/she was hired in March (continued on next page)

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

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2025;-He/she has not worked on his/her class in a couple of months, as it is hard to complete because they can only work on it on their days off. 7. Review of NA W's personnel file showed the following:-Date of hire of 03/19/25 (eight months and twenty days prior);-Staff documented NA W enrolled in the online nurse aide training program on 09/18/25;-Staff did not have documentation NA W had completed the nurse aide training program. During an interview on 12/09/25, at 12:30 P.M., NA W said he/she was hired in March 2025, and started NA classes a couple of months ago. 8. Review of NA S's personnel file showed the following:-Date of hire of 03/06/25 (eight months and three days prior);-Staff documented NA S enrolled in the online nurse aide training program on 10/12/25;-Staff did not have documentation NA S had completed the nurse aide training program. During an interview and observation on 12/09/25, at 12:40 P.M., NA S said the following:-NA S was providing showers to residents;-He/she was hired in January 2025;-He/she started online CNA classes three months ago;-Staff must complete the class on their days off and he/she hasn't worked on it in about a month;-He/she received on-the-job training by following a CNA for about a week;-He/she did not have to have a competency test after completing OJT;-He/she is currently the only shower aide for the facility. 9. Review of NA R's personnel file showed the following:-Date of hire of 05/14/25 (six months and twenty-five days prior);-Staff documented NA R enrolled in the online nurse aide training program on 10/04/25;-Staff did not have documentation NA R had completed the nurse aide training program 10. Review of NA C's personnel file showed the following:-Date of hire of 06/25/25 (five months and fourteen days prior);-Staff documented NA C enrolled in the online nurse aide training program on 10/17/25;-Staff did not have documentation NA C had completed the nurse aide training program. During an interview on 12/05/2025, at 11:49 A.M., NA C said the following:-He/she watched videos and received two weeks on the job training with another CNA;-He/she independently provides cares for residents, unless they are a two-person assist;-He/she has been employed with the facility for approximately five to six months;-He/she is supposed to be enrolled in CNA classes but does not know why he/she is not. He/she has mentioned it to management. During an interview on 12/09/25, at 12:45 P.M., NA C said the following:-The Staff Development Coordinator (SDC) told him/her if staff do not complete the online CNA class by February 2026, they will be terminated;-The Corporate Nurse is supposed to be enrolling him/her in the online CNA class. 11. Review of NA U's personnel file showed the following:-Date of hire of 08/07/25 (four months and two days prior);-Staff documented NA U enrolled in the online nurse aide training program on 10/04/25;-Staff did not have documentation NA U had completed the nurse aide training program. During an interview and observation on 12/04/25, from 10:29 A.M. to 11:50 A.M., NA U said the following:-He/she was pushed one resident in his/her wheelchair down the hall after assisting the resident with a shower;-He/she provided incontinent care for another resident;-He/she started at the facility three or four months ago;-He/she was informed the facility enrolled him/her in the online NA class today (12/04/25). 12. During an interview on 12/09/25, at 12:55 P.M., LPN X said the following:-He/she was unsure when NA's have to start class by, but knows there is a date;-NA's receive training from most experienced CNAs;-He/she was unsure if there is check list or if the NA's must be signed off by nursing staff or management on competency;-If a CNA had a concern with a NA they can talk to a nurse or the Staff Development Coordinator (SDC). During an interview on 12/09/25, at 1:00 P.M., the SDC said the following:-He/she started the position as the SDC in August 2025;-He/she just received his/her credentials in October 2025 to start enrolling staff in CNA training;-The Corporate Nurse had enrolled the most recent NA's in CNA classes;-The facility did not have a sign off or check off list to ensure competency of the NA's after receiving their on-the-job training;-The SDC only completed a competency evaluation of NA's if there has been a complaint;-Current Medical Records Staff (MRS) previously was responsible for enrolling staff in CNA classes;-NA staff should be enrolled immediately in the online CNA class upon hire;-NA's have 120 days to complete the online program. Staff must work on the classes Monday to Friday, from 8:00 A.M. to 5:00 P.M., when management is in the building;-The SDC and the Corporate Nurse are responsible of monitoring the NA's progress in the (continued on next page)

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	class. 14. During an interview on 12/09/2025, at 2:00 P.M., LPN O said the following:-Upon hire, NA's follow a CNA around for approximately a week;-LPN O has previously (a year ago) reviewed NA competency, but currently MR is responsible for competency checks;-NA's complete online CNA classes. During an interview on 12/09/25, at 2:10 P.M., LPN N said the following:-NA's must complete a CNA class either 120 days after employment or after 120 hours on the job;-NA's complete on the job training;-He/she was unsure if there is a competency check off. During an interview on 12/09/25, at 2:50 P.M., MRS said the following:-NA staff have to complete 16 hours of orientation before they can start on the floor;-After the orientation, they are enrolled in online CNA class;-NA's received OJT with a CNA or a NA that is already enrolled in class;-MRS or LPN O used to review NA's for competency;-MRS has not checked a NA for competency since June or July 2025 and has not enrolled a NA in online CNA classes since August 2025;-He/she does not know when the NA's work on their online classes. During an interview on 12/09/25, at 3:43 P.M., the Director of Nursing (DON) said the following:-NA's complete their orientation, and then are placed with a CNA for on the job training;-The DON is unsure how long the NA shadows the CNA;-NA's should be enrolled in CNA classes as soon as they complete their shadowing;-NA's must complete the CNA class and be tested within 120 days of employment;-The CNA classes are online, and staff can work on their class Monday through Friday when management is available; -The SDC and the Corporate Nurse track staff's class progress and completion. During an interview on 12/09/25, at 4:12 P.M., the Administrator said the following:-NA's were paired with CNAs for on the job training;-He/she was unsure if there is a competency check by management;-NA's should be enrolled in CNA classes as soon as possible;-The SDC and the Corporate Nurse are responsible for enrolling NA's in the CNA class;-The CNA class must be complete within 120 days of employment;-He/she was unsure of when NA staff work on their online CNA class;-The facility had NA staff who have worked at the facility longer than 120 days and have not completed their CNA class.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. Based on record review and interviews, the facility failed to implement an antibiotic stewardship program that develops, promotes, and implements a facility wide system that monitors the use of antibiotics, reduces the risk of adverse events associated with antibiotic use, and failed to develop and implement protocols that ensure residents prescribed an antibiotic are utilizing the appropriate one. The facility census was 106.Review of a facility policy titled Infection Prevention and Control Program, dated October 2025, showed the following:-The policy of the facility is to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections;-The designated infection preventionist is responsible for oversight of the program and serves as a consultant to our staff on infectious diseases, resident room placement, implementing isolation precautions, staff and resident exposures, and surveillance, and investigations of exposures of infectious diseases;-A system of surveillance is utilized for prevention, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents and staff;-An antibiotic stewardship program will be implemented as part as the overall infection prevention and control program;-Antibiotic use protocols and a system to monitor antibiotic use will be implemented as part of the antibiotic stewardship program;-The infection preventionist, with the oversight of the Director of Nursing (DON), serves as the leader of the antibiotic stewardship program.1. Review showed the facility did not provide information regarding an antibiotic stewardship program.Review of the facility infection control binder showed the following:-The last weekly infection analysis review occurred on 05/20/25;-The last antibiotic usage review occurred on 05/20/25.During an interview on 12/09/25, at 4:10 P.M., Licensed Practical Nurse (LPN) O said he/she was the wound care nurse and was not on a committee for infection control or antibiotic use. During an interview on 12/09/25, at 2:13 P.M., the DON said the following:-Antibiotic stewardship program should monitor the number of infections and any reoccurring infections in the facility;-The staff should have in-services and training based upon antibiotic findings;-The Assistant Director of Nursing (ADON) highlighted resident infections in a binder to assess clusters of infections in the facility;-The binder did not appear to be up to date upon his/her review;-Antibiotic usage is reviewed weekly in the infection control meeting;-The wound care nurse and ADON had infection control meetings, but he/she did not attend.During an interview on 12/09/25, at 4:12 P.M., the Administrator said he/she did not know about antibiotic stewardship. Infection control is reviewed in Quality Assurance and Performance Improvement (QAPI) meetings. Nurses should be conducting daily meetings that address a variety of topics.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. During an interview on 12/09/25, at 4:12 P.M., the Administrator said he/she did not know about antibiotic stewardship. Infection control is reviewed in Quality Assurance and Performance Improvement (QAPI) meetings. Nurses should be conducting daily meetings that address a variety of topics. Review of a facility policy titled Infection Prevention and Control Program, dated October 2025, showed the following:-The policy of the facility is to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections;-The designated infection preventionist is responsible for oversight of the program and serves as a consultant to our staff on infectious diseases, resident room placement, implementing isolation precautions, staff and resident exposures, and surveillance, and investigations of exposures of infectious diseases;-All staff are responsible for following all policies and procedures related to the program;-A system of surveillance is utilized for prevention, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents and staff;-The infection preventionist serves as the leader in surveillance activities, maintains documentations of incidents, findings, and corrective actions made by the facility and reports surveillance findings to the facility's Quality Assessment and Assurance Committee;-The infection preventionist, with the oversight of the Director of Nursing (DON), serves as the leader of the antibiotic stewardship program;-The infection preventionist shall coordinate screening procedures in case of widespread exposure of staff to any infectious disease.Review showed the facility did not provide a certificate of infection preventionist training for the DON or Assistant Director of Nursing (ADON).During interviews on 12/09/25, at 11:45 A.M., and on 12/09/25, at 2:04 P.M., the corporate nurse said the ADON was the infection preventionist until he/she quit on Monday. The DON was the infection preventionist until the facility hired someone else. He/she was the corporate nurse and is not in the facility much, so he/she was not the infection preventionist. He/she was available to provide guidance to the DON related to infection preventionist role. He/she was not involved in any infection control planning or committees.During an interview on 12/09/25, at 1:37 P.M., the Administrator said the infection control nurse was the ADON, but he/she quit on the day of surveyors' arrival. The corporate nurse was overseeing the DON who had currently taken over as the infection preventionist until another nurse could be hired for position. He/she had not informed the DON of new infection control position yet. He/she did not know if the DON had any infection control training. The corporate nurse was trained in infection control and had always been overseeing it at the facility. During an interview on 12/09/25, at 2:13 P.M., the DON said the following: -He/she had not been advised he/she would be the infection preventionist;-The ADON quit on Monday, and he/she assumed the infection preventionist role would fall on her;-The corporate nurse or Administrator had not advised him/her they would be the new infection preventionist;-He/she signed up to take an infection prevention course today;-He/she was not aware that the ADON was not trained for infection preventionist role prior to quitting.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interview and record review, the facility failed to fully implement their abuse and neglect prevention policies, when the facility failed to complete a criminal background check (CBC), an employee disqualification list (EDL - a list of individual prohibited from working in a long-term care facility in Missouri due to a finding of abuse or neglect) check, and a Nurse Aide (NA) Registry (list of individual with a Federal Indicator (a marker given to a potential employee who has committed abuse, neglect, or misappropriation of property against residents) prohibiting them from working in a certified facility) check for ten sampled staff (Certified Nursing Assistant (CNA) A, Nursing Assistant (NA) B, NA C, Registered Nurse (RN) D, Dietary Aide (DA) E, Certified Medication Technician (CMT) F, Licensed Nurse Practitioner (LPN) G, Laundry Aide (LA) H, NA I, and Dietary Manager (DM)). The facility census was 106.Review of the facility policy titled Background Investigations, dated 10/01/25, showed the following:-Job reference checks, drug screenings, licensure verifications, and criminal conviction record checks are conducted on all personnel making application for employment with this company;-The Human Resource department will conduct all applicable background investigation(s) on each individual making application for employment with this company and on any current employee if such background investigation is appropriate for position for which the individual has applied;-For all applicants applying for a position as a certified nurse aide, the human resources department will contact the nurse aide registry of the state in which the individual is certified and/or previously employed to verify that the applicant's certification is in good standing. 1. Review of CNA A's personnel record showed the following:-Hire date of 08/21/24;-A check of the Family Care Safety Registry (includes a CBC check) and EDL was complete on 12/05/25;-The facility did not have verification showing a check of the NA Registry was complete. 2. Review of NA B personnel record showed the following:-Hire date of 03/12/25;-A check of the Family Care Safety Registry and EDL was complete on 12/05/25;-The facility did not have verification showing a check of the NA Registry was complete. 3. Review of Dietary Manager (DM) personnel record showed the following:-Hire date of 09/17/25;-A check of the Family Care Safety Registry and the EDL was complete on 12/05/25;-The facility did not have verification showing a check of the NA Registry was complete. 4. Review of NA C personnel record showed the following:-Hire date of 06/25/25;-A check of the EDL list was complete on 06/23/25;-The facility did not have verification of a criminal background check requested or received;-A check of the Family Care Safety Registry was complete on 12/05/25;-The facility did not have verification showing a check of the NA Registry was complete. 5. Review of RN D personnel record showed the following:-Hire date of 09/17/25;-A check of the EDL list was complete on 09/16/25;-The facility requested a criminal background check on 09/12/25. No results were received;-The facility did not have verification showing a check of the NA Registry was complete. 6. Review of DA E personnel record showed the following:-Hire date of 04/23/24;-The facility received a criminal background check on 12/18/24;-A check of the EDL list was complete on 01/07/25;-The facility did not have verification showing a check of the NA Registry was complete. 7. Review of CMT F personnel record showed the following:-Hire date of 05/14/24;-The facility received a criminal background check on 12/18/24;-A check of the Family Care Safety Registry and EDL was complete on 12/05/25;-The facility did not have verification showing a check of the NA Registry was complete. 8. Review of LPN G personnel record showed the following:-Hire date of 02/03/25;-The facility received a criminal background check on 02/19/24;-A check of the EDL list was complete on 12/05/25;-The facility did not have verification showing a check of the NA Registry was complete. 9. Review of LA H personnel record showed the following:-Hire date of 09/04/24;-A check of the EDL list was complete on 09/03/24;-The facility received a criminal background check on 12/19/24;-The facility did not have verification showing a check of the NA Registry was complete. 10. Review of NA I personnel record showed the following:-Hire date of 01/15/25;-A check of the EDL list was complete on 01/07/25;-The facility received a criminal background check on 02/19/25;-The facility did not (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	have verification showing a check of the NA Registry was complete. 11. During an interview on 12/09/25, at 12:30 P.M., the Business Office Manager (BOM) said the following:-He/she completed a check of the Family Care Safety Registry (FCSR) and the EDL list;-He/she verifies nurses have an active license and will check the NA Registry on all CNAs and CMTs;-He/she did not check the NA Registry for non-nursing staff;-All background checks were completed prior to staff orientation. During an interview on 12/09/25, at 3:43 P.M., the Director of Nursing (DON) said the following:-The BOM completed staff background checks, which include the FCSR, EDL, criminal background, NA Registry on all nursing staff, and verification of nursing licenses;-He/she was unsure if staff were permitted to work prior to receiving the results of the background check;-Staff cannot work the floor in until NA Registry and nurse license verification is received. During an interview on 12/09/25, at 4:12 P.M., the Administrator said the following:-The BOM completed the background check which consists of the EDL, FCSR, NA Registry, and nurse license check;-The facility only checks the NA registry for CNA staff;-Background checks need to be complete prior to staff working the floor.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interviews, and record review, the facility failed to ensure medications were labeled and stored per standards of practice when insulin pens were not properly labeled and dated, including pens for seven residents (Resident #47, #35, #4, #83, #22, #7, and #33). The facility also failed to maintain the medication storage refrigerator at the recommended temperatures, per manufactures recommendations, for multiple medications stored in the refrigerator for use. The facility had a census of 106.1. Review of a facility procedure titled Insulin Pen, dated 10/01/25, showed the following:-It is the policy of this facility to use insulin pens to improve accuracy of insulin dosing, provide increased resident comfort, and serve as a teaching aid to prepare residents for discharge;-Insulin pens contain multiple doses of insulin but are for a single resident use;-Insulin pens must be clearly labeled with the resident name, physician name, date dispensed, type of insulin, amount to be given, frequency, and expiration date;-If the label is missing, the pen will not be used, and a new pen must be ordered from the pharmacy;-Once opened, clearly labeled insulin pens may be stored at room temperature;-Insulin pens should be disposed of after 28 days or according to manufacturer's recommendations. Review of a facility policy titled Storage and Expiration Dating of Medications and Biologicals dated 06/30/25, showed the following:-Facility should ensure medications that have been retained longer than recommended by the manufacturer guidelines are stored separate from other medications until destroyed;-Facility should record the date opened on the primary medication container when the medication has a shortened expiration date once opened;-If a multi-dose vial of an injectable medication has been opened, the vial should be dated and discarded withing 28 days unless manufacturer specifies a different date;-Facility should destroy and reorder medications with soiled, illegible, worn, incomplete, or missing labels. Review of the Food and Drug Administration (FDA) package insert, dated 05/2019, for insulin glargine (long-acting insulin) showed the following: -Never share the insulin pen between patients, even if the needle is changed;-The insulin pen can be used for 28 days after being opened;-Do not use insulin pen after expiration date. Review of the Food and Drug Administration (FDA) package insert, dated 02/2015, for Novolog Flex Pen (insulin lispro - fast acting insulin) showed the following: -Never share the insulin pen between patients, even if the needle is changed;-The insulin pen can be used for 28 days after being opened;-Do not use insulin pen after expiration date. Review of the Food and Drug Administration (FDA) package insert, dated 09/2018, for Basaglar Kwik Pen (long-acting insulin) showed the following: -Never share the insulin pen between patients, even if the needle is changed;-The insulin pen can be used for 28 days after being opened; -Do not use insulin pen after expiration date. Review of the Food and Drug Administration (FDA) package insert, dated 07/2022, for Tresiba (long-acting insulin) injection pens showed the following: -Never share the insulin pen between patients, even if the needle is changed;-The insulin pen can be used for 56 days after being opened; -Do not use insulin pen after expiration date. 1. Review of Resident #47's face sheet (basic resident profile information) showed the (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	following:-admission date of 01/28/25;-Diagnoses included diabetes mellitus (disorder where the body does not produce enough insulin, causing blood sugar levels to be high). Review of the resident's current Physician Order Sheet (POS) showed an order, dated 05/26/25, for insulin glargine insulin pen 100 units per milliliter (ml); administer 65 units subcutaneously (below the skin) twice daily for diabetes mellitus. Observation of a medication cart on 12/04/25, at 9:45 A.M., showed the resident's insulin glargine pen had no expiration date. 2. Review of Resident #35's face sheet showed the following:-admission date of 01/28/25;-Diagnoses included diabetes mellitus. Review of the resident's current POS showed the following:-An order, dated 09/18/25, for Novolog Flex Pen insulin 100 unit per ml; administer subcutaneously before meals and at bedtime per sliding scale:-If blood sugar is 150 milligrams/deciliter (mg/dL) to 200 mg/dL, give 3 units;-If blood sugar is 201 mg/dL to 250 mg/dL, give 6 units;-If blood sugar is 251 mg/dL to 300 mg/dL, give 9 units;-If blood sugar is 301 mg/dL to 350 mg/dL, give 12 units;-If blood sugar is 351 mg/dL to 400 mg/dL, give 15 units;-If blood sugar is 401 mg/dL to 450 mg/dL, give 18 units;-An order, dated 10/09/24, for insulin glargine insulin pen 100 units per ml; administer 13 units subcutaneously at bedtime. Observation of a medication cart on 12/04/25, at 9:45 A.M., showed the resident's insulin glargine pen had not date opened noted and no expiration date noted. The resident's Novolog insulin pen showed a date of 10/20 written on the pen in marker. Staff did not indicate if this was the date opened or date expired. 3. Review of Resident #4's face sheet showed the following:-admission date of 09/16/25;-Diagnoses included diabetes mellitus. Review of the resident's current POS showed an order, dated 09/23/25, for insulin glargine insulin pen 100 units per ml; administer 23 units subcutaneously twice daily. Observation of a medication cart on 12/04/25, at 9:45 A.M., showed the resident's insulin glargine pen had no expiration date. 4. Review of Resident #83's face sheet showed the following:-admission date of 03/30/23;-Diagnoses included diabetes mellitus. Review of the resident's current POS showed an order, dated 09/23/25, for Basaglar Kwik Pen insulin pen; 100units per ml; administer 15 units subcutaneously at bedtime. Observation of a medication cart on 12/04/25, at 9:45 A.M., showed resident's Basaglar insulin pen showed a date of 10/26 written on the pen in marker. Staff did not note if that was open date or expiration date. 5. Review of Resident #22's face sheet showed the following:-admission date of 08/23/22;-Diagnoses included diabetes mellitus. Review of the resident's current physician order sheet showed an order, dated 05/21/25, for insulin (continued on next page)

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	265307	A. Building B. Wing	12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire Senior Living Webb City	2077 Stadium Drive Webb City, MO 64870

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	glargine insulin pen 100 units per ml; administer 36 units subcutaneously twice daily. Observation of a medication cart on 12/04/25, at 9:45 A.M., showed the resident's insulin glargine pen had no expiration date. 6. Review of Resident #7's face sheet showed the following:-admission date of 06/22/23;-Diagnoses included diabetes mellitus. Review of the resident's current POS showed an order, dated 02/27/25, for insulin lispro (fast acting insulin) insulin pen; 100unit per ml; administer per sliding scale subcutaneously before meals and at bedtime:-If blood sugar is 70 mg/dL to 130 mg/dL, give 0 units;-If blood sugar is 131 mg/dL to 180 mg/dL, give 2 units;-If blood sugar is 181 mg/dL to 240 mg/dL, give 4 units;-If blood sugar is 241 mg/dL to 300 mg/dL, give 6 units;-If blood sugar is 301 mg/dL to 350 mg/dL, give 8 units;-If blood sugar is 351 mg/dL to 400 mg/dL, give 10 units;-If blood sugar is 401 mg/dL to 450 md/dL, give 15 units;-If blood sugar is 451 mg/dL to 500 mg/dL, give 18 units.-If blood sugar is greater than 500 mg/dL, call physician. Observation of a medication cart on 12/04/25, at 9:45 A.M., showed the resident's insulin lispro pen had no expiration date. 7. Review of Resident 33's face sheet showed the following:-admission date of 03/28/25;-Diagnoses included diabetes mellitus. Review of the resident's current POS showed an order, dated 05/16/25, for insulin lispro (fast acting insulin) insulin pen; 100unit per ml; administer per sliding scale subcutaneously before meals and at bedtime:-If blood sugar is 70 mg/dL to 130 mg/dL, give 0 units;-If blood sugar is 131 mg/dL to 180 mg/dL, give 2 units;-If blood sugar is 181 mg/dL to 240 mg/dL, give 4 units;-If blood sugar is 241 mg/dL to 300 mg/dL, give 6 units;-If blood sugar is 301 mg/dL to 350 mg/dL, give 8 units;-If blood sugar is 351 mg/dL to 400 mg/dL, give 10 units;-If blood sugar is 401 mg/dL to 450 mg/dL, give 15 units;-If blood sugar is 451 mg/dL to 500 mg/dL, give 18 units;-If blood sugar is greater than 500 mg/dL, call physician. Observation of a medication cart on 12/04/25, at 9:45 A.M., showed the resident's insulin lispro pen had no expiration date. 8. Observation of a medication cart on 12/04/25, at 9:30 A.M., showed three Tresiba injection pens and one open insulin lispro injection pen were open with no resident name, physician name, date dispensed, amount to be given, frequency, or expiration date indicated. These insulin pens were in a cup with other resident insulin pens. 9. During an interview on 12/04/25, at 9:30 A.M., Licensed Practical Nurse (LPN) G said the following:-Insulin pens should have a resident name listed and be dated with an open and expiration date.;-Insulin should be thrown away 28 days after opening;-Insulin pen and vials should be dated with an open date, an expiration date, and nurse initials;-He/she would destroy a pen with no date as you would not know how long it had been opened;-Insulin pens are to be used by one resident only and should be marked with the resident name;-Any nurse can clean expired medication out the medication, there is no set cleaning schedule;-Medications should be destroyed if they are found with no name or expired. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10. During an interview on 12/04/25, at 9:45 A.M., Licensed Practical Nurse (LPN) P said the following:-Insulin pens are for individual resident use;-Pens should have a date they were opened written on them;-Insulin pens should be discarded 30 days after opening;-The nurse would not know when the pen is expired if there is no date indicated; -An insulin pen without a name or date should be discarded. During an interview on 12/09/25, at 12:35 P.M., LPN N said the following:-Insulin pens should have resident information, be dated, have expiration date, and be initialed by the nurse upon opening;-Insulin pens with no date should be destroyed;-Insulin pens should be thrown away if there is no resident name listed;-Insulin pens are to be used by one resident only. During an interview on 12/09/25, at 2:13 P.M., the Director of Nursing (DON) said the following:-Nurses should verify the resident name, date opened and expiration date on insulin pens;-Insulin pens expire 28 days after opening; -Insulin pens are to be used by one resident only;-Insulin pens should be disposed if there is no resident name listed;-Insulin pens that are not dated should be disposed of as staff would not know how long it had been opened for;-Nurses and Certified Medication Technicians (CMT) should go through the medication cart weekly and dispose of expired and discontinued medications. 11. Review of the facility's policy titled Storage and Expiration Dating of Medications and Biologicals, revised date 06/30/25, showed the following:-Facility should ensure medications and biologicals are stored at their appropriate temperatures according to the United States Pharmacopeia (USP) guidelines for temperature ranges and manufacturer guidance;-Facility staff should monitor the temperature of vaccines twice a day;-Refrigeration temperature should be between 36 degrees Fahrenheit (F) and 46 degrees F. Review of the Centers for Disease Control and Prevention (CDC) Guidelines for vaccines, dated 03/26/21, showed the following:-Never freeze refrigerated vaccines;-Ideal temperature of refrigerated vaccines is 40 degrees F;-Refrigerator temperature should be between 36 degrees F and 46 degrees F. Review of Influenza (flu) vaccine package insert, dated July 2024, showed the following:-Store all vials in refrigerator at 35 degrees F to 46 degrees F;-Do not freeze;-Discard if vaccine has been frozen. Review of Pneumococcal (pneumonia) vaccine package insert, dated March 2024, showed the following:-Should be stored between 36 degrees F and 46 degrees F;-Do not freeze. Review of Hepatitis B (protects against acute and chronic illness) vaccine package insert, undated, showed the following:-Should be stored between 36 degrees F and 46 degrees F;-Do not freeze. Review of Tubersol (used to test for tuberculosis) package insert, undated, showed the following:-The vial should be stored at 35 degrees F to 46 degrees F;-The medication should be discarded if exposed to freezing temperatures. Review of acetaminophen suppository (used to treat pain and or fever) package insert, dated February 2024, showed the following:-May keep the medication in a cool storage at 36 degrees F to 46 degrees F to prevent melting;-Do not allow to freeze. Review of the Novolog package insert, undated, showed the following:-Keep Novolog pen or vial in a cool storage at 36 degrees F and 46 degrees F;-Do not freeze. If has been frozen, discard. Review of Humalog (insulin lispro) package insert, dated March 2024, showed the following:-Keep the Humalog pen or vial in a cool storage at 36 degrees F to 46 degrees F;-Do not allow to freeze. Review of Lantus (insulin) package insert, dated December 2024, showed the following:-Keep the Lantus pen or vial in cool storage at 36 degrees F to 46 degrees F;-Do not allow it to freeze;-Do not put it next to the freezer compartment of the refrigerator or next to a freezer pack. 1. Observation and interview on 12/04/25, at 10:00 A.M., of the medication refrigerator located in the medication room with LPN G showed the following:-The thermometer in the refrigerator read 21 degrees F;-The refrigerator contained resident insulins, tuberculosis testing serum, influenza vaccine, pneumococcal vaccine, hepatitis B vaccine, and acetaminophen suppositories;-LPN G said that the (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	temperature should be between 25 degrees F and 32 degrees F. He/she said that night shift nurse checks the refrigerator temperature and should document it on the log nightly. Observation and interview on 12/05/25, at 10:45 A.M., of the medication refrigerator located in the medication room with LPN O showed the following:-The thermometer in the refrigerator read 22 degrees F;-LPN O said that he/she was not sure what the temperature of the refrigerator should be. He/she did not know who was responsible for checking the temperature of the refrigerator and logging it;-The refrigerator contained 20 pre-filled syringes of pneumococcal Prevnar vaccine; one vial of Hepatitis B vaccine; 18 pre-filled syringes of influenza vaccine; two vials of tuberculosis testing solution, seven insulin pens; and 12 acetaminophen suppositories. Review of the refrigerator logs, obtained from a clear sleeve from the front of the refrigerator, showed staff signed and completed the logs for the following days in the month of October 2025:-On 10/03/25, staff noted the temperature was 32 degrees F;-On 10/04/25, staff noted the temperature was 32 degrees F;-On 10/05/25, staff noted the temperature was 32 degrees F;-On 10/08/25, staff noted the temperature was 32 degrees F;-On 10/09/25, staff noted the temperature was 32 degrees F;-On 10/13/25, staff noted the temperature was 33 degrees F;-On 10/14/25, staff noted the temperature was 32 degrees F;-On 10/17/25, staff noted the temperature was 33 degrees F;-On 10/18/25, staff noted the temperature was 32 degrees F;-On 10/19/25, staff noted the temperature was 32 degrees F;-On 10/22/25, staff noted the temperature was 33 degrees F;-On 10/27/25, staff noted the temperature was 33 degrees F;-On 10/28/25, staff noted the temperature was 32 degrees F;-On 10/31/25, staff noted the temperature was 33 degrees F. Review of the refrigerator logs, obtained from a clear sleeve from the front of the refrigerator, showed staff signed and completed the logs for the following days in the month of November 2025:-On 11/01/25, staff noted the temperature was 32 degrees F;-On 11/02/25, staff noted the temperature was 32 degrees F;-On 11/19/25, staff noted the temperature was 33 degrees F;-On 11/20/25, staff noted the temperature was 33 degrees F;-On 11/24/25, staff noted the temperature was 33 degrees F;-On 11/25/25, staff noted the temperature was 33 degrees F;-On 11/28/25, staff noted the temperature was 32 degrees F;-On 11/29/25, staff noted the temperature was 33 degrees F. Review of the refrigerator logs, obtained from a clear sleeve from the front of the refrigerator, showed staff signed and completed the logs for the following days in the month of December 2025:-On 12/03/25, staff noted the temperature was 32 degrees F. During an interview on 12/09/25, at 4:04 P.M., Maintenance Director said that he/she was not allowed in the medication room without a nurse. He/she did not know how often the medication refrigerator was checked and had nothing to do with checking the temperature of the refrigerator. He/she had not been notified of anything being wrong with the refrigerator. During an interview on 12/05/25, at 11:30 A.M., the Director of Nursing (DON) said the night shift nurse was responsible for checking the refrigerator temperature and charting it on the log every night. Staff should contact the DON immediately if the temperature was out of range and the DON would contact maintenance to check the refrigerator. The DON was not sure what the temperature range should be. He/she has not been auditing the temperature log but should have been. Medications were to be kept at specific temperatures and if not kept at the recommended temperature, the medication should not be used until checking with pharmacy. During an interview on 12/05/25, at 12:22 P.M. the Administrator said that the DON was responsible for ensuring that the medication refrigerator temperature was checked daily. He/she expected the DON to report any temperatures that are out of range immediately so that they can figure out how to get the refrigerator fixed. He/she said the temperature range should be between 32 degrees F to 35 degrees F.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to maintain a complete and effective infection prevention and control program when the facility failed to ensure staff were educated on enhanced barrier precautions (EBP - infection control interventions designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities); failed to ensure staff wore appropriate protective personal equipment (PPE) when providing catheter (flexible tubing that is used to drain urine from the bladder) care for one resident (Resident #46) and when accessing a percutaneous endoscopic gastrostomy (PEG - a tube inserted through the abdominal wall in the stomach to provide nutrients) tube for one resident (Resident #62). The facility also failed to maintain an effective infection prevention and control program when the facility failed to have processes in place to ensure all new staff were screened prior to employment for tuberculosis (TB - a serious illness that mainly affects the lungs and can be spread when a person with the illness coughs, sneezes or sings) when the facility failed to fully complete TB testing for nine staff (Certified Medication Technician (CMT) F, Nurse Assistant (NA) I, Licensed Practical Nurse (LPN) G, Dietary Aide (DA) E, NA B, NA C, Laundry Aide (LA) A, Registered Nurse (RN) D, and Dietary Manager (DM)). The facility census was 106.1. Review of the Centers for Disease Control's (CDC) Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-Resistant Organisms, dated 07/12/22, showed the following:-Multidrug-Resistant Organisms (MDRO - microorganisms that are resistant to one or more classes of antimicrobial agents) transmission is common in skilled nursing facilities, contributing to substantial resident morbidity and mortality and increased healthcare costs;-EBP are infection control interventions designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities;-EBP may be indicated (when contact precautions do not otherwise apply) for residents with any of the following: wounds or indwelling medical devices, regardless of MDRO colonization status, and infection or colonization with an MDRO;-Effective implementation of EBP requires staff training on the proper use of PPE and the availability of PPE and hand hygiene supplies at the point of care;-EBP use of PPE refers to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing;-Examples of high-contact resident care activities requiring gown and glove use for EBP includes dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use such as central line, urinary catheter, feeding tube, and tracheostomy/ventilator, and wound care on any skin opening requiring a dressing;-Post clear signage on the door or wall outside of the resident room indicating the type of precautions and required PPE; -Make PPE, including gowns and gloves, available immediately outside of the resident room. Review of the facility's policy titled, Infection Prevention and Control Program, dated 10/01/25, showed the following:-The facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections;-All staff and responsible for following all policies and procedures related to the program;-A system of surveillance is utilized for prevention, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents;-All staff should use PPE according to established facility policy governing the use of PPE. Review of the facility's policy titled, Enhanced Barrier Precautions, dated 10/01/25, showed the following:-It is the policy of this facility to implement EBP for the prevention of transmission of multidrug resistant organisms;-An order for EBP will be obtained for residents with any of the following:-Wounds and indwelling medical devices even if the resident is not known to be infected or colonized with an MDRO-Infection or colonization with a MDRO when contact precautions do not (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	otherwise apply;-Make gown and gloves available immediately near or outside of the resident's room;-PPE for EBP is only necessary when preforming high-contact care activities and may not need to be donned prior to entering the resident's room;-Ensure access to alcohol-based hand rub in every resident room;-Position a trash can inside the resident room and near the exit for discarding PPE after removal, prior to exit of the room or providing care for another resident in the same room;-The infection Preventionist will incorporate periodic monitoring and assessment of adherence to determine the need for additional training and education;-High-contact resident care activities include dressing; bathing; transferring; providing hygiene; changing linens; changing briefs or assisting with toileting; device care or use; and wound care;-Enhanced barrier precautions should be used for the duration of the affected resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk. Review showed the facility did not provide a list of current residents on EBP. 2. Review of Resident #46's face sheet (basic resident profile information) showed the following:-admission date of 03/13/22;-Diagnoses included end stage renal disease (ESRD – kidneys are severely damaged and can no longer filter blood effectively), neuromuscular dysfunction of the bladder (nerve damage disrupts signals between the brain and the bladder causing issues with holding or emptying urine), and multiple sclerosis (a chronic autoimmune disease that affects the central nervous system). Review of the resident's most recent comprehensive Minimum Data Set (MDS-federally mandated assessment tool administered by staff) showed the resident had an indwelling catheter. Review of the resident's care plan, revised 11/21/25, showed staff did not care plan use of a catheter or EBP related to the catheter. Review of the resident's current Physician Order Sheet (POS) showed the following orders:-An order, dated 07/17/25, to change foley catheter every three weeks to prevent urinary tract infections per urology;-An order, dated 06/26/25, to provide foley catheter care every shift;-An order, dated 06/26/25, for a foley catheter 16 French with a 30 milliliter (ml) bulb (size) to closed urinary bag due to diagnosis of retention;-An order, dated 08/18/25, resident required EBP due to foley catheter. Observation of catheter care on 12/09/25, at 10:25 A.M., showed the following:-Certified Nurse Assistant (CNA) J and Nurse Assistant (NA) K provided catheter care to the resident and donned gloves. The CNA and NA did not don a gown;-CNA J and NA K gathered trash, washed hands, and exited room. Observation on 12/09/25, at 10:25 A.M., showed the resident had an EBP sign on the door and gowns located on the back of the door. During an interview on 12/09/25, at 10:35 A.M., CNA J said the following:-EBP is indicated by a sign on the resident's door;-Staff should wear a gown and gloves when caring for residents with open wounds, catheters, and feeding tubes;-He/she should have worn a gown when providing catheter care for resident but forgot. 3. Review of Resident #62's face showed the following:-admission date of 09/02/22;-Diagnoses included hemiplegia following cerebral infarction (paralysis of one side following a brain injury), aphasia (a communication disorder impairing the person's ability to speak), and dysphagia (difficulty swallowing foods or liquids). Review of the resident's care plan, revised 11/25/25, showed the following:-Resident had a PEG tube for nutritional support, hydration, and medication administration;-Staff should utilize EBP when providing personal cares. Review of the resident's current POS showed the following:-An order, dated 09/25/25, for Jevity 1.5 (a brand of liquid nutrition used in tube feedings) bolus feeding per PEG tube, administer 2 cans three times daily, flush with 100 ml water before and after each bolus feeding. Oservation of a tube feeding on 12/03/25, at 1:40 P.M., showed the following:-Licensed Practical Nurse (LPN) L entered the resident's room, washed his/her hands, and donned gloves to provide a feeding via PEG tube. The LPN did not don a gown;-LPN L provided the feeding to the resident, removed gloves, and washed hands. Observation on 12/03/25, at 10:40 P.M., showed the resident had an EBP sign on the door and gowns located on the back of the door. 4. During an interview on 12/03/25, at 12:04 P.M., CNA V said the following:-He/she was not sure what the EBP signs on the resident doors indicated;-He/she thought something was going on in the resident room;-He/she would not do anything different before entering a room with EBP sign on the door;-He/she did not know (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	where the gowns were kept;-He/she was not sure if a gown and gloves would be needed to provide care to residents with a foley catheter or wound. During an interview on 12/09/25, at 12:35 P.M., LPN N said the following:-EBP was for residents with foley catheters, tube feedings, or intravenous lines;-Staff should wear gowns, gloves, and a face mask if needed, when providing direct care to residents;-There should be a sign on the door indicating resident is on EBP and gowns are located behind the door. During an interview on 12/09/25, at 3:48 P.M., CNA M said the following:-EBP were used for residents that have feeding tubes, wounds, and catheters;-Staff should wear gown and gloves for any direct contact with residents on EBP. During an interview on 12/09/25, at 2:13 P.M., the Director of Nursing (DON) said the following:-EBP were for residents with wounds and infections;-Residents with intravenous lines, tube feeding, and catheters are not on EBP;-A resident with a catheter could be on EBP if they had an infection;-EBP was for resident protection;-Staff should wear a gown and gloves for direct contact with EBP residents; -He/she did not know what residents were on EBP currently;-They did not keep a list of EBP residents. During an interview on 12/09/25, at 4:16 P.M., the Administrator said staff should be following EBP and wearing a gown and gloves. Staff should follow infection control guidelines. 5. Review of the facility policy titled, Employee Tuberculosis Testing, dated 10/01/25, showed the following:-At the time of employment, all new staff shall undergo pre-placement screening for Tuberculosis (TB), including an individual risk assessment, TB symptom screen, and a TB test;-All new staff shall receive two Mantoux Tb Skin Tests given two weeks apart (two step testing);-All initial and follow up TB tests shall be administered and interpreted (48 to 72 hours for skin tests) by a trained healthcare provider on our staff, or any licensed physician. Review of 19 CSR 20-20.100 Tuberculosis Testing for Residents and Workers in Long-Term Care Facilities showed the following:-Long-term care facilities shall screen their residents and staff for tuberculosis using the Mantoux method purified protein derivative (PPD) five tuberculin unit (5 TU) test;-Each facility shall be responsible for ensuring that all test results are completed, and that documentation is maintained for all residents, employees, and volunteers;-All new long-term care facility employees and volunteers who work ten or more hours per week are required to obtain a Mantoux PPD two-step tuberculin test within one month prior to starting employment in the facility;-If the initial test is zero to nine millimeters (mm), the second test should be given as soon as possible within three weeks after employment begins, unless documentation is provided indicating a Mantoux PPD test in the past and at least one subsequent annual test within the past two years;-It is the responsibility of each facility to maintain a documentation of each employee's and volunteer's tuberculin status. 6. Review of CMT F's personnel record showed the following:-Hire date of 05/14/24;-The first step of the TB skin test was complete on 05/14/24;-Staff did not document the test was read within 48 to 72 hours;-Staff did not have documentation of completion of the second step TB skin test. 7. Review of NA I's personnel record showed the following:-Hire date of 01/15/25;-The first step of the TB skin test was complete on 01/14/25;-Staff did not document the test was read within 48 to 72 hours;-Staff did not have documentation of completion of the second step TB skin test. 8. Review of LPN G's personnel record showed the following:-Hire date of 02/03/25;-The first step of the TB skin test was complete on 01/19/25;-Staff did not document the test was read within 48 to 72 hours;-Staff did not have documentation of completion of the second step TB skin test. 9. Review of DA E's personnel record showed the following:-Hire date of 04/23/24;-The first step of the TB skin test was complete on 04/23/24;-Staff did not document the test was read within 48 to 72 hours. 10. Review of NA B's personnel record showed the following:-Hire date of 03/12/25;-The first step of the TB skin test was complete on 03/04/25 and read on 03/06/25;-Staff did not have documentation of completion of the second step TB skin test. 11. Review of NA C's personnel record showed the following:-Hire date of 06/25/25;-The first step of the TB skin test was complete on 07/02/25 and read on 07/05/25. 12. Review of LA A's personnel record showed the following:-Hire date of 09/04/24;-The first step of 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
	265307	A. Building B. Wing	12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire Senior Living Webb City	2077 Stadium Drive Webb City, MO 64870

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	TB skin test was complete on 08/27/24 and read on 08/29/24;-The results were not documented in millimeters;-The second step of the TB skin test was complete on 09/10/24 and read on 09/12/24;-The results were not documented in millimeters. 13. Review of RN D's personnel record showed the following:-Hire date of 09/17/25;-The first step of the TB skin test was complete on 09/10/25 and read on 09/12/25;-The results were not documented in millimeters;-The second step of the TB skin test was complete on 09/26/25 and read on 09/28/25;-The results were not documented in millimeters. 14. Review of DM personnel record showed the following:-Hire date of 09/17/25;-The first step of the TB skin test was complete on 09/17/25 and read on 09/19/25;-The results were not documented in millimeters;-The second step of the TB skin test was complete on 10/03/25 and read on 10/05/25;-The results were not documented in millimeters. 15. During an interview on 12/09/25, at 12:30 P.M., the Business Office Manager (BOM) said the following:-TB testing was complete prior to orientation;-The Staff Development Coordinator (SDC) conducted staff TB testing; however, any nurse can complete it. During an interview on 12/09/25, at 12:55 P.M., LPN X said facility nurses can administer staff or resident TB testing. The SDC is responsible for staff TB testing. During an interview on 12/09/25, at 1:00 P.M., the SDC said the following;-He/she conducted a two-step test on all new employees;-He/she provided staff an appointment card to remind them of their second step TB test and also flagged the employee in his/her appointment book;-He/she only had to indicate whether the test is positive or negative, measurements do not have to be recorded;-TB tests were read two days after administered and the second step is completed two weeks after the first step. During an interview on 12/09/25, at 2:00 P.M., LPN O said management conducted staff TB testing. TB tests were read within 48 hours and measurements had to be documented. During an interview on 12/09/25, at 2:10 P.M., LPN N said the SDC conducted staff TB testing. Tests were read within 48 to 72 hours and measurements needed to be documented. During an interview on 12/09/25, at 3:00 P.M., Medical Records (MR) said the following:-New employees receive a two-step TB test;-TB tests are read within 48 hours;-The second TB test is administered with 10 days to two weeks after the first test;-Measurements of the test results should be documented. During an interview on 12/09/25, at 3:43 P.M., the Director of Nursing (DON) said the following:-The SDC or MR conducted new hire TB testing;-A two-step test was complete;-The test was read within 72 hours, and was read during the staff's onboarding process;-The second set was complete two weeks after the first;-The results were to be documented in millimeters. During an interview on 12/09/25, at 4:12 P.M., the Administrator said the following:-New employees receive a two-step TB test;-The test was read three days from the day it was administered;-He/she was unsure when the second step was administered;-Test results were documented as positive or negative. He/she is unsure if a measurement was documented.

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, record review, and interviews, the facility failed to ensure a medication error rate of less than 5% when staff made two errors out of 29 opportunities resulting in an 6.9% error rate when facility staff failed to administer one medication as ordered and administered an incorrect dosage of a medication to one resident (Resident #47). The facility had a census of 106.Based on observation, record review, and interviews, the facility failed to ensure a medication error rate of less than 5% when staff made two errors out of 29 opportunities resulting in an 6.9% error rate when facility staff failed to administer one medication as ordered and administered an incorrect dosage of a medication to one resident (Resident #47). The facility had a census of 106.Review of the facility procedure titled Safe Administration Practiced, Long-Term Care, dated 05/19/25, showed the following:-Be sure to administer daily, weekly, and monthly medications within two hours of the scheduled administration time;-Consult the practitioner if there are unresolved concerns related to prescribed medications;-Documentation associated with safe medication administration would include medication name, strength, and dose. 1. Review of Resident #47's face sheet showed the following:-admission date of 03/01/23;-Diagnoses included high blood pressure and diabetes mellitus (disorder where the body does not produce enough insulin, causing blood sugar levels to be high). Review of the resident's current Physician Order Sheet (POS) showed the following:-An order, dated 08/28/24, for metformin (diabetic medication) 500 milligrams (mg) tablet, give two tablets two times a day for diabetes;-An order, dated 09/27/24, for dorzolamide-timolol (medication to treat increased pressure in the eye) eye drops, instill one drop in both eyes two times daily glaucoma. Review of the resident's December 2025 Medication Administration Record (MAR) showed the following:-Dorzolamide-Timolol eye drops, administer one drop to each eye twice daily, noted as not given on 12/09/25 at 8:00 A.M. due to drug not available;-Metformin tablet 500 mg, administer two tablets twice a day for diabetes mellitus, noted as given as ordered on 12/09/25 at 8:00 A.M. Observation of a medication pass on 12/09/25, at 9:27 A.M., showed the following: -Certified Medication Tech (CMT) Z sanitized his/her hands and started to prepare medications to administer to the resident;-The CMT pulled the metformin card from the medication cart, and it had a dosage of 500 mg and stated to administer two tablets on the label for a total dosage of 1000 mg;-The CMT placed one metformin tablet in the medication cup to administer;-The dorzolamide-timolol was not in the medication cart and unavailable for administration at the ordered time;-The CMT locked the cart and went to the medication room to obtain the dorzolamide-timolol eye drops. The CMT returned with two boxes of eye drops and indicated they were not the correct ones and put them in the cart;-The CMT then entered the resident's room and administered the medications. During an interview and observation on 12/09/25, at 9:30 A.M., CMT Z reviewed the order for metformin and stated he/she should have given two tablets as ordered.The dorzolamide-timolol eye drops were unavailable, but he/she should have administered them as ordered. During an interview on 12/09/25, at 12:35 PM., Licensed Practical Nurse (LPN) N said physician orders should be followed, and staff should administer the correct medication dosage. It would be a medication error to omit an ordered medication or to administer the incorrect dose. Nurses or CMT's should check the medication dispensing system to see if the medication is available and if not contact the pharmacy to send it right away. During an interview on 12/09/25, at 3:30 P.M., CMT M said it would be a medication error if the wrong dose of a medication was administered. He/she would notify the charge nurse, and the nurse would contact the physician. Medications that are not given at the correct time or are not available would be a medication error. During an interview on 12/09/25, at 3:55 P.M., LPN Y said it would be a medication error if the wrong dose of a medication was given to a resident. He/she would notify the physician, family, and the Director of Nursing (DON). A medication omitted during the medication pass is an error. The CMT should notify the charge nurse if there is a medication error. During an interview on 12/09/25, at 2:13 P.M., the DON said staff should follow physician orders when (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	administering medications. It would be a medication error if the correct dosage was not given or if a medication was not available for administration as ordered Nurses should notify the resident's family and physician for a medication error. A progress note should be entered for a medication error. During an interview on 12/09/25, at 4:16 P.M., the Administrator said nurses and CMT's should follow physician orders when administering medications.