STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265309	A. Building B. Wing	06/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire Senior Living Joplin	2218 W 32nd Street Joplin, MO 64804

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, and record review, the facility failed to ensure all residents were treated with dignity and respect, when staff did not assist one resident (Resident #4) to leave the dining room to have a soiled brief changed before mealtime. The facility census was 111. Review of a facility policy titled Resident Rights, dated January 2024, showed the following:-The purpose of the policy is to ensure resident rights are protected, respected, and promoted;-The facility will treat each resident with dignity and care for each resident in a manner and environment that promotes quality of life;-The resident has the right to live in the facility and receive services with reasonable accommodation of needs and preferences. 1. Review of Resident #4's face sheet showed the following:-admission date of 03/04/36;-Diagnoses included stroke and congestive heart failure (CHF - impaired heart function). Review of the resident's care plan, dated 03/18/26, showed the following:-Impaired physical mobility;-Assist resident in performing tasks;-Resident dependent on one to two staff for toileting;-Dependent on two staff for transfer;-Resident had bowel incontinence;-Staff should check and change brief as needed. Review of the resident's admission Minimum Data Set (MDS - a federally mandated comprehensive assessment instrument completed by facility staff), dated 03/19/26 showed the following:-Resident cognitively intact;-Resident dependent on staff for toileting, mobility, and showering;-Incontinent of bladder and bowel. Observation and interview on 05/28/26, at 2:55 P.M., showed the following: -The resident rested in bed watching television;-He/she said a few days ago in the dining room he/she had pooped in his/her pants. He/she had asked Certified Nurse Aide (CNA) F to return to the room to get changed prior to eating;-CNA F told the resident to wait and he/she did not want to take him/her back to the room;-CNA F accused the resident of trying to trick staff to help him/her with a brief change;-The resident said he/she felt embarrassed due to smelling bad and having a soiled brief;-The resident was crying in the dining room and CNA D took him/her to the room to change and brought him/her back to the dining room for lunch;-The resident started crying during when telling of the event. During an interview on 05/28/26, at 12:02 P.M., Certified Nurse Assistant (CNA) D said the following: -He/she observed CNA F assist the resident into the dining room;-He/she observed the resident had a large bowel movement. He/she stated the resident had bowel coming out of the brief;-He/she overheard the resident ask CNA F to go back to the room and have the brief changed;-CNA F told the resident they should eat and shut up;-CNA D assisted the resident back to the room to change briefs after CNA F left the resident at the table;-He/she reported the incident to the Director of Nursing (DON) or Assistant Director of Nursing (ADON). During an interview on 06/01/26, at 11:46 A.M., Certified Medication Technician (CMT) H said the following: -A resident should not eat with a soiled brief;-He/she would take the resident to the room to change and then return them to the dining room to eat. During an interview on 05/28/26, at 1:12 P.M., Licensed Practical Nurse (LPN) C said the following:-CNA's should take residents to be changed and then bring them back to dining room if soiled;-Residents should be treated with dignity and respect and it was not ok to tell a resident to shut up. During an interview on 05/28/26, at 1:52 P.M., LPN E said the following: -Residents should be taken back to the room to get changed and then returned to the dining room;-Residents should not be soiled in the dining room or told to shut up. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/01/26, at 11:54 A.M., LPN I said the following:-Residents should be treated with dignity and respect;-Residents should be changed if they are soiled;-He/she would take the resident from the dining room to change them and bring them back. During an interview on 06/01/26, at 11:21 A.M., Registered Nurse (RN) G said -Providing dignity and respect to residents included assuring a resident is clean and changed;-A resident should not wait to be changed after a meal;-Staff should take a resident to the room to be changed and return them to the dining area. During an interview on 06/01/26, at 2:53 P.M., RN J said the following:-A resident should be changed if found to be soiled in the dining room;-Residents should be provided with dignity and respect by keeping them clean. During an interview on 06/01/26, at 3:16 P.M., the ADON said the following: -Incontinence care should be provided every two hours and as needed;-A resident should not be allowed to eat with a soiled brief;-Any staff could assist the resident to the room to change and return them to the dining area;-An aide should not refuse to change a resident until after lunch as it could affect their dignity. During an interview on 06/01/26, at 3:44 P.M., the DON said the following: -Staff should treat residents with kindness, empathy, and meet their needs;-Staff should change a soiled resident prior to eating;-It would affect the resident's dignity to eat in the dining room with a soiled brief. During an interview on 06/01/26, at 4:47 P.M., the Administrator said the following:-Residents should be treated with dignity and respect;-Incontinence care should be provided every two hours and as needed;-A resident should not be allowed to eat with a soiled brief;-Staff should take the resident to be changed when requested;-Eating in the dining room with a soiled brief could affect the resident's dignity. Complaint #2981469 and #3022586

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on interview and record review, the facility failed to ensure residents only self-administered medication after it had been determined to be clinically appropriate when one resident (Resident #2) self-administered insulin injections independently without an assessment to determine competency or a physician order to allow for self-administration and failed to include self-administration of medication on the resident's care plan. The facility census was 111. Review of a facility policy titled Medication Self-Administration, dated 01/30/24, showed the following:-The purpose of the policy is to establish uniform guidelines concerning resident self-administration of medications;-Residents are not permitted to administer medications unless their primary physician writes an order for self-administration of the medication and the interdisciplinary team determines the resident Is able to safely self-administer medications;-An evaluation/assessment of the resident's ability to self-administer medications will be conducted and documented;-The physician order must be signed and dated prior to self-administration;-The staff charge nurse will counsel the resident on the proper use of medications initially as well as often as necessary and the resident medical record will reflect all counseling;-Self-administration of medications will be reflected on the resident's care plan and reviewed quarterly as well as with any clinical change in status. 1. Review of Resident #2's face sheet (a document that gives a resident's information at a quick glance) showed the following:-admission date of 03/22/24;-Diagnoses included chronic obstructive pulmonary disease (COPD-a progressive, incurable lung disease that causes severe breathing difficulties by obstructing airflow, primarily through bronchitis or emphysema) and diabetes mellitus (metabolic disease). Review of the resident's care plan, revised 01/28/26, showed the following:-Resident required assistance to complete daily activities of care safely;-Resident had fluctuation of blood sugar results with diabetes mellitus and noncompliance with diet;-Administer medications per order and evaluate, record, and report effectiveness and adverse side effects.(Staff did not care plan regarding the resident self-administering his/her insulin.) Review of the resident's medical record showed the staff did not have documentation of a self-administration of medication assessment for the resident. Review of the resident's progress note, dated 03/23/26, showed the following: -The resident requested to self-administer his/her insulin;-Resident observed giving self insulin injection using proper technique;-Staff will continue to draw insulin up as directed;-Resident care planned to self-administer when he/she requests to do so. (Staff did not document physician notification to obtain a physician's order.) Review of the resident's progress note, dated 04/08/26, showed the following: -Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff) note;-Resident was an insulin dependent diabetic and had requested to self-inject insulin after the nurse sets it up;-Nurse present and observes injection with proper technique to inject, secure the safety sheath to cover needle, and dispose of needle in sharps container. (Staff did not document physician notification to obtain a physician's order.) Review of the resident's current Physician's Order Sheet (POS) showed an order, dated 05/05/26, for insulin glargine (long-acting insulin used to treat diabetes) solution 100 units per milliliter (ml), inject 60 units subcutaneously (beneath the skin) one time a day for diabetes. (Staff did not document an order for self-administration of medications.) Review of the resident's May 2026 Medication Administrator Record (MAR) showed insulin glargine documented as administered by staff. Review of the resident's May 2026 progress notes showed no further documentation related to self-administration of insulin. During an interview with on 05/28/26, at 10:28 A.M., the resident said the following:-He/she checked his/her own blood sugar and self-administered insulin injections;-Staff provided his/her with a glucometer and supplies to check blood sugars;-He/she showed the staff the blood sugar result;-The staff prepared the insulin injection based upon the blood sugar result and allowed him/her to inject the insulin. During an interview on 06/01/26, at 11:21 A.M, Registered Nurse (RN) G said the following:-Residents require a physician order to self-administer medications;-The nurse should (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	monitor residents who self-administer medication during administration;-Blood sugar checks and insulin administration are not typically able to be self-administered by residents;-He/she does blood sugar checks and insulin administration for the resident. During an interview on 06/01/26, at 2:36 P.M., Licensed Practical Nurse (LPN) C said the following:-He/she was unsure if a resident required a physician order to self-administer medication;-The resident had self-administration of medication included on the care plan;-He/she would draw up the medication and monitor the resident if he/she requested to self-administer insulin. During an interview on 06/01/26, at 2:53 P.M., RN J said the resident administered his/her own insulin injections. The nurse will draw up the correct dosage and give the resident the syringe. The resident was care planned to self-administer medications. During an interview on 06/01/26, at 3:16 P.M., the Assistant Director of Nursing (ADON) said he/she was unaware if the resident administered his/her own medication. A resident that self-administered medication should have a physician order and the information should be included in the care plan. During an interview on 06/01/26, at 3:44 P.M., the Director of Nursing (DON) said residents require a physician order to self-administer medications. The resident self-administers his/her own insulin after the nurses pull up the correct dose. He/she should have a physician order, and it should be included in the care plan. During an interview on 06/01/26, at 4:47 P.M., the Administrator said residents should have a physician order to self-administer medication. The care plan should be updated to include resident self-administration of medications. Complaint # 3022586

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident?s advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, facility staff failed to ensure a resident's wishes regarding a Do Not Resuscitate (DNR- an order signed by a physician that instructs healthcare providers not to perform cardio-pulmonary resuscitation (CPR - an emergency procedure that is performed when a person's heartbeat or breathing has stopped) if a resident's breathing or heart stops) order was honored when staff performed CPR for one resident (Resident #1). The facility census was 111. Review of the facility's policy titled, Basic Life Support/CPR, revised [DATE], showed the following:-The purpose of the policy is to ensure that properly trained personnel are available to provide basic life support to residents requiring emergency care prior to the arrival of emergency personnel, and subject to accepted professional guidelines, resident advance directive (written instructions recognized under state law relating to the provision of care if the resident is incapacitated), and physician orders;-Potential rescuers will initiate CPR unless a valid DNR order is in place;-The facility staff must provide basic life support, including CPR, prior to the arrival of emergency medical services (EMS) in accordance with the resident's advance directive or any related physician order, and in the absence of an advance directive or DNR order;-Facility policy will address how resident preferences and physician orders related to CPR and other advance directive issues are communicated throughout the facility so that staff know immediately what action to take or not take when an emergency arises. 1. Review of Resident #1's face sheet (a document that gives a resident's information at a quick glance) showed the following:-admission date of [DATE];-The face sheet did not indicate code status;-Diagnoses included chronic obstructive pulmonary disease (COPD-a progressive, incurable lung disease that causes severe breathing difficulties by obstructing airflow, primarily through bronchitis or emphysema), congestive heart failure (CHF - impaired heart function), and diabetes mellitus (metabolic disease). Review of the resident's care plan, dated [DATE], showed the resident's code status was a DNR. Review of the resident's current Physician's Order Sheet (POS) showed an order, dated [DATE], for DNR. Review of an Outside Hospital Do Not Resuscitate Order (OHDNR) showed the resident signed the order on [DATE] and a physician signature dated [DATE]. Review of the resident's progress note dated [DATE], at 10:41 A.M., showed the following: -The resident was found in the dining room unresponsive at approximately 8:45 A.M.;-DNR status was verified after CPR initiated;-The resident's time of death called by this nurse and wound nurse at approximately 8:51 A.M.;-Staff notified family friend and coroner;-Funeral home picked resident up at approximately 10:29 A.M.;-Resident out of facility at approximately 10:35 A.M. During an interview on [DATE], at 11:32 A.M., Certified Nurse Aide (CNA) B said the following:-He/she observed the resident sitting in the dining room after breakfast;-A housekeeper attempted to move the resident out of the dining room, and he/she went limp;-He/she called for a nurse and tried to wake the resident up;-The resident's lips were blue and he/she appeared to not take a breath for a while;-Another CNA and a hospice nurse came into the dining room and started CPR;-LPN C entered the dining room and advised the CNA and hospice nurse to stop CPR as the resident was a DNR;-The resident code status can be found in a binder at the nurses' station or in the plan of care;-CPR should not be done on a resident with a DNR order. During an interview on [DATE], at 1:12P.M., Licensed Practical Nurse (LPN) C said the following:-A resident's code status appeared in the medical record and in a code status book at the nurse station;-The resident was found unresponsive with his/her heart stopped in the dining room;-He/she was called to the dining room by an aide;-An aide and a hospice nurse had started CPR on the resident by the time he/she arrived to assist;-He/she went to check the resident's code status and saw the resident was a DNR;-He/she returned to the dining room and informed the aide and hospice nurse to stop CPR;-CPR should be given to a resident until the code status is confirmed. During an interview on [DATE], at 11:15 A.M., CNA A said the following;-The resident's code status (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	can be found at the nurses' station;-He/she does not know anywhere else the code status could be located;-He/she would get the nurse right away for an unresponsive resident. During an interview on [DATE], at 12:02 P.M., CNA D said the following:-If a resident was found unresponsive, staff should notify the charge nurse and verify the resident's code status;-He/she was unsure where to find a resident code status but would ask the nurse. During an interview on [DATE], at 1:52 P.M., LPN E said the following:-He/she would stay with an unresponsive resident and have someone check code status;-He/she would not start CPR until the code status was known;-CPR should not be given to a resident with a DNR order;-A resident's code status can be found in the chart or a code book at the nurse station. During an interview on [DATE], at 3:20 P.M., CNA F said the following:-Code status can be found in a book at the nurses' station;-He/she would start CPR immediately on an unresponsive resident until confirmation of a DNR order;-He/she would yell for help and have another staff check the resident code status. During an interview on [DATE], at 11:46 A.M., Certified Medication Technician (CMT) H said the following:-The nurse will let the aides know a resident code status or they can find it in a code book at the nurses' station;-The CNAs and CMTs are not allowed to initiate CPR;-He/she would get a nurse if a resident was found to be unresponsive;-CPR should not be given to a resident with a DNR order. During an interview on [DATE], at 11:54 A.M., LPN I said the following:-Code status can be found on the care plan or a book at the nurses' station;-CPR should not be given to a resident without knowing code status;-Administering CPR to a DNR resident would be against physician orders. During an interview on [DATE], at 11:21 A.M., Registered Nurse (RN) G said the following:-Resident code status can be found on the resident profile page and in a binder at the nurses' station;-CPR should not be started before checking residents code status;-A resident with a DNR order should not be given CPR. During an interview on [DATE], at 2:53 P.M., RN J said the following:-Code status can be found in on the medication administration record, resident orders, and in the code binders at the nurse station;-Nurses should check code status prior to starting CPR;-CPR should not be administered to a DNR resident. During an interview on [DATE], at 11:15 A.M., the Social Services Director (SSD) said the following:-The admission nurse assessed a residents code status on admission;-He/she reviewed code status monthly, ensured an order was in place, and entered code status in the care plan;-Code status was reviewed monthly, quarterly, annually, and upon a change in condition;-He/she printed DNR orders on purple paper and placed them in the code status folders at both nurse stations. During an interview on [DATE], at 3:16 P.M., the Assistant Director of Nursing (ADON) said the following:-The resident code status was indicated in a book on both halls and should be listed on the care plan;-The SSD was responsible for updating the code status in the book;-CNAs should not initiate CPR;-Staff should yell for help for an unresponsive resident, check the code book, and initiate CPR if indicated;-CPR should not be given to a resident with a DNR order. During an interview on [DATE], at 3:44 P.M., the Director of Nursing (DON) said the following:-He/she heard the resident went down in the dining room and a hospice nurse was present;-CPR was started on the resident, but was stopped after learning of DNR order;-CNA's should contact the nurse and not initiate CPR;-Code status should be checked in the code book at the nurses' station;-CPR should not be given to a resident with a DNR. During an interview on [DATE], at 4:47 P.M., the Administrator said a resident's code status should be honored. Staff should check the resident's code status prior to starting CPR. Complaint #3022586 and #3025981

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to provide care per standards of practice when staff failed to complete ordered daily weights, failed to notify physician as ordered regarding excess weight gain, failed to document and monitor the resident's fluid restriction and intake, and failed to care plan new intervention for one resident (Resident #1) with a diagnosis of congestive heart failure (CHF - impaired heart function) contributing to the resident's hospitalization with severe hyponatremia (low sodium), hypervolemia (fluid overload), abdominal distention, and lower extremity edema. The facility census was 111. Review of the facility policy titled Notification of Changes, dated January 2024, showed the following:-The purpose is to ensure resident and/or representative notification of specific changes during the resident's stay at the facility;-The facility must immediately inform the resident, consult with the resident physician, and notify the resident representative when there is a significant change in the resident's physical, mental, or psychosocial status or decision to transfer a resident from the facility. Review of the facility policy titled Fluid Restriction, dated January 2024, showed the following:-It is the policy of the facility to ensure that fluid restrictions are followed in accordance with physician orders;-The nurse will obtain and verify the physician order for fluid restriction and an order written to include the breakdown of fluid per 24-hour period and will be recorded on the medication record;-The food and nutrition department will be notified by facility communication methods of the fluid restriction. 1. Review of Resident #1's face sheet (a general information sheet) showed the following: -admission date of 02/05/26;-Diagnoses included chronic obstructive pulmonary disease (COPD-a progressive, incurable lung disease that causes severe breathing difficulties by obstructing airflow, primarily through bronchitis or emphysema), congestive heart failure (CHF - impaired heart function), chronic kidney disease (CKD - damaged kidneys), stage 3B (moderately reduced kidney function), and diabetes mellitus (metabolic disease). Review of the resident's current Physician's Order Sheet (POS) showed the following:-An order, dated 02/09/26, for Lasix (diuretic - medication to decrease fluid in the body) tablet 20 milligrams (mg), give 1 tablet by mouth in the morning for edema (swelling).-An order, dated 02/23/26, for a daily weight in the morning for CHF. Call heart clinic for weight gain of 3 pounds overnight or 5 pounds in one week. Review of the resident's care plan, dated 04/17/26, showed staff did not care plan regarding the resident's diagnosis of CHF, his/her diuretic (medication to decrease fluid in the body) medication, or ordered daily weights. Review of the resident's weight showed the following: -On 02/24/26, a weight of 157.0 pounds;-On 02/26/26, a weight of 172.0 pounds. Review of the resident's progress notes showed staff did not document notification of the resident's physician or heart clinic regarding the 15-pound weight gain in two days. Review of the resident's weight showed the following: -On 02/27/26, at 7:30 A.M., a weight of 172.3 pounds;-On 02/27/26, at 11:06 A.M., a weight of 172.0 pounds;-On 02/28/26, a weight of 172.8 pounds;-On 03/01/26, a weight of 171 pounds;-On 03/02/26, a weight of 171.4 pounds;-On 03/03/26, a weight of 168.4 pounds. Review of the resident's medical record, dated 03/04/26, showed staff did not document a weight obtained or a resident refusal of weight check. Review of the resident's weight on 03/05/26 showed a weight of 170 pounds. Review of the resident's medical record, dated 03/06/26, showed staff did not document a weight obtained or a resident refusal of weight check. Review of the resident's weight on 03/07/26, at 6:46 A.M., showed a weight of 176.0 pounds. (A six-pound increase in two days.) Review of the resident's weight on 03/07/26, at 12:44 P.M., showed the resident was reweighed and showed a weight of 174.0 pounds. (A four-pound increase in two days.) Review of the resident's progress notes showed staff did not document notification of the resident's physician or heart clinic of the four-pound weight gain in two days. Review of the resident's medical record, dated 03/08/26, showed staff did not document a weight obtained or a resident refusal of weight check. Review of the resident's weight showed the following: -On 03/09/26, a weight of 174.5 pounds;-On 03/10/26, a weight of 171.0 (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	pounds;-On 03/10/26, at 10:40 P.M., showed a weight of 174.3 pounds;-On 03/11/26, a weight of 178.5 pounds (a 3.8-pound increase in one day.) Review of the resident's progress note dated 03/11/26, at 12:48 P.M., showed the following: -Resident had over three-pound weight gain in one day;-Resident had visible fluid filling up in his/her right shoulder, so much so that there looked to be a softball of fluid on resident's right shoulder;-Nurse Practitioner (NP) aware of change in shoulder and that it was painful to the touch;-Resident said NP planned on draining it; -No extra diuretic dose sought out from physician for weight gain due to explanation of it. Review of the resident's progress note dated 03/11/26, at 10:33 P.M., showed the physician ordered prednisone (steroid medication) 40 milligrams (mg) daily for 5 days and blood sugar checks three times daily with standard insulin (medication to control blood sugar) sliding scale for administration while on prednisone. Review of the resident's current POS showed the following orders:-An order, dated 03/11/26, for prednisone 20 mg tablets, give 2 tablets one time a day for corticosteroids for 5 days;-An order, dated 03/11/26, for blood sugar check three times a day for five days due to on prednisone.(Staff did not include the insulin sliding scale on the POS.) Review of the resident's March 2026 Medication Administration Record (MAR) showed the following:-Staff documented prednisone administered as ordered except on 03/14/26 when staff noted it not administered due to vital signs out of parameters for administration (no parameters for administration noted the physician's order);-Blood glucose checks documented as completed as ordered. Review of the resident's record showed staff did not document weights from 03/12/26 through 03/15/26. Review of the resident's weight on 03/16/26 showed a weight of 173.6 pounds. Review of the resident's progress note, dated 03/16/26, showed the following: -The occupational therapist assistant documented during therapy session the resident looked distended in abdominal region;-Resident said he/she had increased difficulty in breathing and said, My lungs feel like they are filling with fluid;-Nursing staff notified, and nebulizer (breathing medication) administered;-NP notified. Review of the resident's weight on 03/17/26 showed a weight of 172 pounds. Review of the resident's progress note, dated 03/17/26, showed the following: -Orders received from NP for labs and chest x-ray due to shortness of breath;-Orders entered;-Chest x-ray results sent to NP tonight with new orders for cefdinir (antibiotic) 300 mg twice daily for 10 days;-Diuretics were increased on dayshift per order. Review of the resident's current POS showed the following orders:-An order, dated 03/17/26, for cefdinir 300 mg capsule, give 1 capsule two times a day for pneumonia for 10 days;-An order, dated 03/17/26, for torsemide (medication to treat excess fluid retention) 40 mg tablet, give one tablet once daily for edema (swelling from fluid retention). Review of the resident March 2026 MAR showed staff administered the cefdinir and torsemide as ordered. Review of the resident's weight on 03/18/26 showed a weight of 176 pounds (a four-pound weight gain. Review of the resident's progress note, dated 03/18/26, showed the following: -A noted 4-pound weight gain overnight from 172 lbs. to 176 pounds;-Staff attempted to reach heart clinic but got no response. Staff left a message;-Resident remains stable and eating breakfast in dining room;-Staff will continue to monitor. Review of the resident's weight showed the following: -On 03/19/26, a weight of 176.6 pounds;-On 03/20/26, a weight of 176.6 pounds;-On 03/21/26, a weight of 172.4 pounds. Review of the resident's medical record, dated 03/22/26, showed staff did not document a weight obtained or a resident refusal of weight check. Review of the resident's weight showed the following -On 03/23/26, a weight of 171.6 pounds.-On 03/24/26, a weight of 170.8 pounds. Review of the resident's medical record, dated 03/25/26, showed staff did not document a weight obtained or a resident refusal of weight check. Review of the resident's weight on 03/26/26, showed a weight of 174.4 pounds (an increase of 3.6 pounds). Review of the resident's progress notes, dated 03/26/26, showed staff did not document notification of the resident's physician or heart clinic of 3.6-pound weight gain. Review of the resident's weights showed the following: -On 03/27/26, a weight of 174.2 pounds.-On 03/28/26, a weight of 174.1 pounds.-On 03/29/26, a weight of 173.4 pounds.-On 03/30/26, a weight of 173.2 pounds.-On 03/31/26, a weight of 173.0 pounds.-On 04/01/26, a weight of 185 pounds (a 12-pound weight gain in one night.) Review of the resident's (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	progress notes showed staff did not documentation of notification of the physician or heart clinic of 12 pounds weight gain in one day. Review of the resident's weight on 04/02/26, showed a weight of 189 pounds (a four-pound weight gain). Review of the resident's progress notes showed staff did not document notification of the physician or heart clinic of four-pound weight gain in one day. Review of the resident's progress note, dated 04/02/26, showed the resident admitted to the hospital due to labs out of normal limits. Review of the resident's hospital discharge note, dated 04/10/26, showed the following:-The resident was a direct admit from the neurology clinic due to severe hyponatremia (low sodium), lower extremity edema, right shoulder effusion (accumulation of excess fluid), and pain;-Resident reported over the last week his/her legs were swelling, he/she was weaker, and had increased shortness of breath;-Resident admitted from neurologist due to sodium level of 122 (normal sodium levels are 135 to 145) and significant swelling to the belly, swelling to right shoulder, and weakness to the lower extremities;-Resident discharged back to the facility on [DATE] with diagnoses of urinary tract infection, CKD, stage 4 (severely decreased kidney function), severe hyponatremia, hypervolemia (fluid overload), abdominal distention, lower extremity edema, and CHF. Review of the resident's progress note, dated 04/10/26, showed resident readmitted today from the hospital. Resident alert and orientated and on a regular diet. Resident on 1500 ml fluid restriction. Review of the resident's April 2026 MAR showed staff did document the order for fluid restriction. Review of resident's April 2026 intake and output record showed staff did not document intake for the resident. Review of the resident's weights showed no readmission weight on 04/10/26. Review of the resident's progress note, dated 04/11/26, showed resident alert and oriented with no signs of difficulty breathing or shortness of breath noted and no oxygen or cough. Head of the bed elevated to 30 degrees. No cough. Review of the resident's record, dated 04/11/26, showed staff did not document a weight for the resident. Review of the resident's weight on 04/12/26, showed a weight of 188.0 pounds. Review of the resident's progress note, dated 04/12/26, showed resident reported difficulty breathing. Tachypnea (rapid, shallow breathing) present. Resident reported orthopnea (shortness of breath that occurs when lying flat). Nurse observed orthopnea and tachypnea present. Shortness of breath noted. Nurse observed shortness of breath (while sitting and lying flat. (Staff did not document physician notification or interventions implemented.) Review of the resident's record showed staff did not document a weight on 04/13/26. Review of the resident's weight on 04/14/26, showed a weight of 197.8 pounds (an increase of 9.8 pounds in two days). Review of the resident's progress notes showed staff did not document notification of the physician or heart clinic of 9.8 pounds weight gain. Review of the resident's dietary profile, dated 04/14/26, showed the resident was on a regular diet with no fluid restriction. Review of the resident's weight on 04/15/26, showed a weight of 197.0 pounds. Review of the resident's weight on 04/16/26, showed a weight of 199.4 pounds (an increase of 2.4 pounds in one day.) Review of the resident's progress notes showed staff did not document notification of the physician or heart clinic of 2.4 pounds weight gain in one day. Review of the resident's progress note, dated 04/16/26, showed the resident reported shortness of breath and shortness of breath with exertion. Head of the bed elevated to facilitate breathing. Resident declined to attempt to lay flat for assessment of shortness of breath when lying flat. Resident stated that he/she was already short of breath, why would I want to make it worse. (Staff did not document physician notification.) Review of the resident's progress note, dated 04/17/26, showed the resident reported he/she had been having increased anxiety and shortness of air. Resident continued to wake up throughout the night. Physician notified and placed a new order for Ativan (used to treat anxiety) 0.5 mg, 1 tab every 6 hours as needed. During an interview on 06/01/26, at 11:21 A.M., Registered Nurse (RN) G said the following:-Aides were responsible for obtaining weights but the nurse can help;-The nurse should make a list of all weights needed daily;-The nurse should notify the physician if there is a large change in weight;-The nurse should see how the resident was weighed and recheck if the weight appeared to be off;-The physician should be notified if a CHF patient has a weight gain of two pounds in a day or five pounds in a week. During an (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	interview on 06/01/26, at 11:54 A.M., Licensed Practical Nurse (LPN) I said aides were responsible for obtaining weights. The resident was a daily weight, and the physician should be notified for a weight gain of three pounds overnight or five pounds in a week. During an interview on 06/01/26, at 12:20 P.M., the Dietary Manager said the following:-The nurse provided a diet communication form for a change in diet or fluid restriction;-The diet change should automatically be updated in the chart;-The diet communication should indicate what fluids a resident on fluid restriction is allowed;-He/she could not remember if the resident was on fluid restriction. During an interview on 06/01/26, at 2:36 P.M., LPN C said the weights due for the day pop up on the nurses' MAR. The aides will obtain weights and the nurse, or the aide will document them. The physician should be notified if a CHF resident gains three pounds in 24 hours or five pounds in 72 hours. He/she could not recall if the physician was notified for the resident's weight gain, but they should have been. During an interview on 06/01/26, at 2:53 P.M., RN J said the following:-The aides help with daily weights, and the restorative aide does weekly and monthly weights;-Fluid restriction orders should be included on the MAR;-Staff should be monitoring the resident fluid intake;-The nurse is responsible for making sure the weights are completed;-The nurse should complete a daily list of weights that are needed;-The physician should be notified if a CHF resident gains three pounds in 24 hours or five pounds in a week;-He/she thought the Nurse Practitioner (NP) was notified of the residents weight gain but was unsure if it was documented;-The physician or NP should have been notified, and the nurse should have completed a progress note;-They did make some medication changes for the resident. During an interview on 06/01/26, at 3:16 P.M., the Assistant Director of Nursing (ADON) said the following:-Aides or nurses should chart the weights daily;-CHF residents should have orders indicating when to call the physician for weight changes;-Nursing and kitchen staff should monitor intake and output for residents on fluid restriction;-The physician should have been notified of the fluid restriction order upon the resident return from the hospital. During an interview on 06/01/26, at 3:44 P.M. the Director of Nursing (DON) said the following: -The restorative aide received a list of weights and was responsible for completing them;-The weights should be entered into the medical record;-The nurse should notify the physician if a CHF resident has a three-pound weight gain in one day;-The nurse should reweigh the resident and possibly check the wheelchair if the weight is off. During an interview on 06/16/26, at 9:22 A.M., the attending physician said the following:-He/she would expect staff to notify him/her of a weight change of three pounds in a day or 15 pounds in a week;-He/she should have been notified of the weight gain, but was not;-Staff should be rechecking weights if they have that amount of weight gain;-He/she did not think that the weight gain of 12 pounds in one day or 42 pounds in a 6-week period would be correct;-Staff should be following orders for fluid restrictions;-Increased fluid could have resulted in weight gain;-He/she should be notified if a resident had shortness of breath. During an interview on 06/01/26, at 4:47 P.M., the Administrator said staff should be following physician orders. Residents should be monitored after a change of condition, the physician should be notified, and all information documented in a progress note. Complaint #3022586 and #3025981

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide pharmaceutical services to meet the needs of each resident when a nurse reinitiated an order for Naltrexone (medication used to treat alcohol and opioid disorders) without a physician order for one resident (Resident # 5). The facility census was 111.Review of the facility policy titled Medication Administration, dated October 2025, showed medications are administered by licensed nurses, or other staff legally authorized to do so, as ordered by a physician and in accordance with professional standards of practice. 1. Review of Resident #5's face sheet (a document that gives a resident's information at a quick glance) showed the following:-admission date of 04/22/26;-Diagnoses included alcohol abuse. Review of the resident's current Physician Order Sheet (POS) showed the following:-An order, dated 04/22/26, for Naltrexone tablet 50 milligrams (mg), give 0.5 tablet by mouth in the morning for alcohol abuse. The order was discontinued on 04/23/26;-An order, dated 04/22/26, for hydrocodone-acetaminophen tablet 5-325 mg, give one tablet by mouth every eight hours as needed for pain. Review of the resident's April 2026 Medication Administration Record (MAR) showed an order, dated 04/22/26, for Naltrexone tablet 50 mg, give 0.5 tablet by mouth in the morning for alcohol abuse. Staff did not document as administered Review of the resident's nursing progress note, dated 04/22/26, showed resident admitted to skilled rehabilitation on this date. Resident's Naltrexone was discontinued per physician. Hydrocodone 5-325 mg every 8 hours as needed was added for pain. Review of the resident's care plan, dated 04/24/26, showed staff did not care plan the resident's history of alcohol abuse or the use of naltrexone, or pain medication. Review of the resident's current POS showed an order, dated 04/25/26, for Naltrexone tablet 50 mg, give 0.5 tablet by mouth one time a day due to alcohol abuse. Review of the resident's order progress note, dated 04/25/26, showed the following: -The order for Naltrexone oral tablet 50 mg, give 0.5 tablet by mouth one time a day due to alcohol abuse has a possible drug interaction with the following orders: hydrocodone-acetaminophen tablet 5-325 mg, give 1 tablet by mouth every 8 hours as needed for pain;-Naltrexone may decrease the pharmacologic effects of hydrocodone-acetaminophen tablet 5-325 mg. Coadministration of naltrexone and hydrocodone-acetaminophen tablet 5-325 mg may precipitate withdrawal symptoms in individuals who are physically dependent on opioids;-Naltrexone therapy should be suspended in patients receiving intermittent opioid treatment. Review of the resident's April 2026 MAR showed the following:-An order, dated 04/25/26, for Naltrexone tablet 50 mg, give 0.5 tablet by mouth one time a day. Staff documented the Naltrexone was administered on 04/25/26 and 04/26/26;-An order, dated 04/22/26, for hydrocodone-acetaminophen tablet 5-325 mg, give 1 tablet by mouth every 8 hours as needed. Staff documented hydrocodone-acetaminophen as administered on 04/25/26 at 12:11 A.M. and 5:48 P.M Review of the resident's deleted (due to a reason of incomplete documentation) nursing progress note, dated 04/27/26, showed Naltrexone was discontinued per physician order on the day of admission. Please see admission note this nurse submitted on resident's day of admission [DATE]). Per physician this medication was discontinued. This medication was reactivated without physician's consent or orders to do so. This nurse has now discontinued Naltrexone again. During an interview on 05/28/26, at 1:12 P.M., Licensed Practical Nurse (LPN) C said the following:-The physician must be contacted for any order;-The physician is contacted for a new order, the nurse enters it into the electronic health record, and a progress note is entered regarding the order. During an interview on 05/28/26, at 1:12 P.M., LPN E said the following:-The nurse should contact the physician to obtain a new order;-The new order should be put into the electronic medical record;-The nurse should document a progress note about the reason for contacting the physician, the orders received, and notification to the resident and family;-An LPN reactivated an order without physician approval;-The LPN said he/she reactivated the order due to feeling the resident needed it due to alcohol (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	abuse;-He/she discontinued the order as the physician discontinued the order on admission due to ordering narcotic pain medication. During an interview on 06/01/26, at 11:21 A.M., Registered Nurse (RN) G said nurses should not be writing orders without contacting the physician. Nurses should follow physician orders. During an interview on 06/01/26, at 11:54 A.M., Certified Medication Technician (CMT) H said staff should follow physician orders. It is not ok to write your own orders for residents. During an interview on 06/01/26, at 2:36 P.M., LPN C said the following:-Resident came to the facility with an order for Naltrexone but it was discontinued that day;-He/she did not believe the nurse called the physician for a new Naltrexone order;-The physician should be contacted for all orders, and those orders should be followed. During an interview on 06/01/26, at 2:53 P.M., RN J said the resident's Naltrexone was discontinued on admission due to the physician starting pan medication. He/she did not know why it had been restarted. During an interview on 06/01/26, at 3:16 P.M., the Assistant Director of Nursing (ADON) said nurses should not be writing own orders. Nurses should always contact the physician for orders and follow those orders. During an interview on 06/01/26, at 3:44 P.M, the Director of Nursing (DON) said the following:-He/she discovered the Naltrexone order incident while reviewing progress notes;-The restarting of the Naltrexone was a medication error. During an interview on 06/01/26, at 4:47 P.M., the Administrator said staff should be following physician orders. Nurses should not be writing orders without contacting the physician. During an interview on 06/16/26, at 9:22 A.M., the attending physician said the following:-The Naltrexone was discontinued due to initiating narcotic pain medication;-The Naltrexone and pain medication cannot be given together;-He/she would not and did not restart the Naltrexone;-The resident could become sick and have diarrhea and nausea if the two medications were given together;-He/she was not notified the Naltrexone had been restarted or administered;-The initiation and administration of Naltrexone would be considered a medication error. Complaint #3022586

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility staff failed to ensure all residents were free of significant medication errors when staff failed to administer insulin for two residents (Resident #1 and #6) per physician order. The facility census was 111.Review of a facility policy titled Medication Administration, dated October 2025, showed the following:-Medications are administered by licensed nurses, or other staff legally authorized to do so, as ordered by a physician and in accordance with professional standards of practice;-Obtain and record vital signs and hold medication when vital signs are outside of the prescribed physician standards;-Sign the Medication Administration Record (MAR) after medication administration;-Report and document any adverse side effects or refusals. Review of a facility policy titled Medication Errors and Drug Reactions, dated January 2024, showed the following:-The purpose is to establish guidelines for reporting and recording of medication errors to safeguard the resident;-All medication errors must be promptly reported to the Director of Nursing (DON), physician, pharmacist, resident, and the Administrator;-A medication error is the observed, identified preparation, or administration of the medications which are not in accordance with the prescribers order. 1. Review of Resident #1's face sheet (a document that gives a resident's information at a quick glance) showed the following:-admission date of 02/05/26;-Diagnoses included diabetes mellitus (metabolic disease). Review of the resident's care plan, dated 02/16/26, showed the following:-Resident had diabetes mellitus;-Resident had potential nutritional problems related to diabetes mellitus with insulin;-Administer medications as ordered and monitor and document side effects and effectiveness. Review of the resident's current Physician Order Sheet (POS) showed an order, dated 02/14/26, for insulin glargine (long-acting insulin to treat diabetes) solution 100 units per milliliter (ml), inject 10 units subcutaneously (under the skin) one time a day for diabetes. Review of the resident's March 2026 MAR showed on 03/02/26, staff did not administer insulin as ordered, did not indicate a blood sugar reading, and documented to see progress note. Review of the resident's progress note, dated 03/02/26, showed staff did not document an indication for holding the medication or notification to the physician of medication not administered. Review of the resident's March 2026 MAR showed on 03/03/26, staff did not administer insulin as ordered, did not indicate a blood sugar reading, and documented to see progress note. Review of the resident's progress note, dated 03/03/26, showed staff did not document an indication for holding the medication or notification to the physician of medication not administered. Review of the resident's March 2026 MAR showed on 03/06/26, staff did not administer insulin as ordered, did not indicate a blood sugar reading, and documented to see progress note. Review of the resident's progress note, dated 03/06/26, showed staff did not document an indication for holding the medication or notification to the physician of medication not administered. Review of the resident's March 2026 MAR showed on 03/07/26, staff did not administer insulin as ordered, did not indicate a blood sugar reading, and documented to see progress note. Review of the resident's progress note, dated 03/07/26, showed staff did not document an indication for holding the medication or notification to the physician of medication not administered. Review of the resident's March 2026 MAR showed on 03/09/26, staff did not administer insulin as ordered, did not indicate a blood sugar reading, and documented as a resident refusal. Review of the resident's progress notes, dated 03/09/26, showed staff did not document notification to the physician of the refusal. Review of the resident's March 2026 MAR showed on 03/11/26, staff did not administer insulin as ordered, did not indicate a blood sugar reading, and documented as a resident refusal. Review of the resident's progress notes, dated 03/11/26, showed staff did not document notification to the physician of the refusal. Review of the resident's March 2026 MAR showed on 03/12/26, staff did not administer insulin as ordered, did not indicate a blood sugar reading, and documented no insulin required. (The insulin order did not contain parameters indicating to hold medication.) Review of the resident's progress notes, dated 03/12/26, (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	showed staff did not document an indication for holding the medication or notification to the physician. Review of the resident's March 2026 MAR showed on 03/17/26, staff did not administer insulin as ordered, indicated a blood sugar reading of 171 milligram per deciliter (mg/dL) (normal pre-meal blood sugar range is 80 mg/dL to 130 mg/dL, or less than 180 mg/dL after eating), and documented no insulin required. (The insulin order did not contain parameters indicating to hold medication.) Review of the resident's progress notes, dated 03/17/26, showed staff did not document notification of the physician. Review of the resident's March 2026 MAR showed on 03/22/26, staff did not administer insulin as ordered, indicated a blood sugar reading of 177 mg/dL and documented no insulin required. (The insulin order did not contain parameters indicating to hold medication.) Review of the resident's progress notes, dated 03/22/26, showed staff did not document notification of the physician. Review of the resident's March 2026 MAR showed on 03/25/26, staff did not administer insulin as ordered, did not indicate a blood sugar reading, and documented no insulin required. (The insulin order did not contain parameters indicating to hold medication.) Review of the resident's progress notes, dated 03/25/26, showed staff did not document an indication for holding the medication or notification of the physician. Review of the resident's March 2026 MAR showed on 03/26/26, staff did not administer insulin as ordered, did not indicate a blood sugar reading, and documented no insulin required. (The insulin order did not contain parameters indicating to hold medication.) Review of the resident's progress notes, dated 03/26/26, showed staff did not document an indication for holding the medication or notification to the physician. Review of the resident's March 2026 MAR showed on 03/27/26, staff did not administer insulin as ordered, indicated a blood sugar reading of 185 mg/dL, and documented no insulin required. (The insulin order did not contain parameters indicating to hold medication.) Review of the resident's progress notes, dated 03/27/26, showed staff did not document notification of the physician. Review of the resident's March 2026 MAR showed on 03/28/26, staff did not indicate a blood sugar reading and did not document medication administration. Review of the resident's progress notes, dated 03/28/26, showed staff did not document an indication for holding the medication or notification to the physician. Review of the resident's March 2026 MAR showed on 03/30/26, staff did not administer insulin as ordered, indicated a blood sugar reading of 162 mg/dL, and documented no insulin required. (The insulin order did not contain parameters indicating to hold medication.) Review of the resident's progress notes, dated 03/30/26, showed staff did not document notification of the physician. Review of the resident's March 2026 MAR showed on 03/31/26, staff did not administer insulin as ordered, indicated a blood sugar reading of 153 mg/dL and documented no insulin required. (The insulin order did not contain parameters indicating to hold medication.) Review of the resident's progress notes, dated 03/31/26, showed staff did not document notification of the physician. Review of the resident's April 2026 MAR showed on 04/01/26, staff did not administer insulin as ordered, did not indicate a blood sugar reading, and documented resident refused. Review of the resident's progress notes, dated 04/01/26, showed staff did not document notification of the physician of the resident's refusal. Review of the resident's medical record showed the resident out of the facility at the hospital from [DATE] to 04/10/26. Record review of the resident's current POS showed an order, dated 04/10/26, for insulin glargine solution 100 units per ml, inject 15 units subcutaneously one time a day for diabetes. (The insulin order did not contain parameters indicating to hold medication.) Review of the resident's April 2026 MAR showed on 04/10/26, staff did not administer insulin as ordered, indicated a blood sugar reading of 89 mg/dL, and documented no insulin required. (The insulin order did not contain parameters indicating to hold medication.) Review of the resident's progress notes, dated 04/20/26, showed staff did not document notification of the physician. Review of the resident's April 2026 MAR showed on 04/12/26, staff did not administer insulin as ordered, did not indicate a blood sugar reading , and documented hold, see progress report. (The insulin order did not contain parameters indicating to hold medication.) Review of the resident's progress notes, dated 04/12/25, showed staff did not document indication for holding the medication or notification of the physician. Review of the (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire Senior Living Joplin	2218 W 32nd Street Joplin, MO 64804

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's April 2026 MAR showed on 04/13/26, staff did not administer insulin as ordered, indicated a blood sugar reading of not applicable, and documented no insulin required. (The insulin order did not contain parameters indicating to hold medication.) Review of the resident's progress notes, dated 04/13/25, showed staff did not document notification of the physician. Review of the resident's April 2026 MAR showed on 04/14/26, staff did not administer insulin as ordered, did not indicate a blood sugar reading, and documented no insulin required. (The insulin order did not contain parameters indicating to hold medication.) Review of the resident's progress notes, dated 04/14/26, showed did not document notification of the physician. Review of the resident's April 2026 MAR showed on 04/15/26, staff did not administer insulin as ordered, indicated a blood sugar reading of not applicable, and documented no insulin required. (The insulin order did not contain parameters indicating to hold medication.) Review of the resident's progress notes, dated 04/15/26, showed staff did not document notification to the physician. Review of the resident's April 2026 MAR showed on 04/16/26, staff did not administer insulin as ordered, indicated a blood sugar reading of 176 mg/dL, and documented no insulin required. (The insulin order did not contain parameters indicating to hold medication.) Review of the resident's progress notes, dated 04/16/26, showed staff did not document notification of the physician. 2. Review of Resident # 6's face sheet showed the following:-admission date of 05/11/26;-Diagnoses included diabetes mellitus. Review of the resident's care plan, dated 03/04/26, showed the following:-Resident had diabetes mellitus;-Diabetes medication as ordered by doctor;-Monitor/document for side effects and effectiveness. Record review of the resident's current POS showed an order, dated 05/11/26, for Lantus (long-acting insulin for diabetes) subcutaneous solution pen-injector 100 units per ml, inject 48 unit subcutaneously two times a day for diabetes. Review of the resident's May 2026 MAR showed on the morning of 05/12/26, staff did not administer insulin as ordered, blood sugar documented as 76 mg/dL, and staff documented vital signs outside of parameters to be given. (The insulin order did not contain parameters indicating to hold medication.) Review of the resident's progress notes, dated 05/12/26, showed staff did not document notification of the physician. Review of the resident's May 2026 MAR showed on the morning of 05/13/26, staff did not administer insulin as ordered, no blood sugar documented, and staff documented resident refused. Review of the resident's progress notes, dated 05/13/26, showed staff did not document notification of the physician. Review of the resident's May 2026 MAR showed on the morning of 05/16/26, staff did not administer insulin as ordered, blood sugar documented as 87 mg/dL, and staff documented vital signs outside of parameters to be given. (The insulin order did not contain parameters indicating to hold medication.) Review of the resident's progress notes, dated 05/16/26, showed staff did not document notification to the physician. Review of the resident's May 2026 MAR showed on the morning of 05/17/26, staff did not administer insulin as ordered, blood sugar documented as 85 mg/dL, and staff documented vital signs outside of parameters to be given. (The insulin order did not contain parameters indicating to hold medication.) Review of the resident's progress notes, dated 05/17/26, showed staff did not document notification of the physician. Review of the resident's May 2026 MAR showed on the morning of 05/18/26, staff did not administer insulin as ordered, indicated a blood sugar reading of 68 mg/dL, and documented no insulin required. (The insulin order did not contain parameters indicating to hold medication.) Review of the resident's progress notes, dated 05/18/26, showed staff did not document notification of the physician. Review of the resident's May 2026 MAR showed on the morning of 05/19/26, staff did not administer insulin as ordered, indicated a blood sugar reading of 95 mg/dL, and documented no insulin required. (The insulin order did not contain parameters indicating to hold medication.) Review of the resident's progress notes, dated 05/19/26, showed staff did not document notification of the physician. Review of the resident's May 2026 MAR showed on the morning of 05/20/26, staff did not administer insulin as ordered, blood sugar documented as 74 mg/dL, and staff documented vital signs outside of parameters to be given. (The insulin order did not contain parameters indicating to hold medication.) Review of the resident's progress notes, dated 05/20/26, showed staff did not document notification (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of the physician. Review of the resident's May 2026 MAR showed on the morning of 05/21/26, staff did not administer insulin as ordered, blood sugar documented as 63 mg/dL, and staff documented vital signs outside of parameters to be given. (The insulin order did not contain parameters indicating to hold medication.) Review of the resident's progress notes, dated 05/21/26, showed staff did not document notification of the physician. Review of the resident's May 2026 MAR showed on the morning of 05/22/26, staff did not administer insulin as ordered, blood sugar documented as 80 mg/dL, and staff documented vital signs outside of parameters to be given. (The insulin order did not contain parameters indicating to hold medication.) Review of the resident's progress notes, dated 05/22/26, showed staff did not document notification of the physician. Review of the resident's May 2026 MAR showed on the evening of 05/22/26, staff did not administer insulin as ordered, blood sugar documented as 133 mg/dL, and staff documented vital signs outside of parameters to be given. (The insulin order did not contain parameters indicating to hold medication.) Review of the resident's progress notes, dated 05/22/26, showed staff did not document notification of the physician. Review of the resident's May 2026 MAR showed on the morning of 05/23/26, staff did not administer insulin as ordered, blood sugar documented as 117 mg/dL, and staff documented vital signs outside of parameters to be given. (The insulin order did not contain parameters indicating to hold medication.) Review of the resident's progress notes, dated 05/23/26, showed staff did not document notification of the physician. Review of the resident's May 2026 MAR showed on the evening of 05/22/26, staff did not administer insulin as ordered, blood sugar documented as 129 mg/dL, and staff documented vital signs outside of parameters to be given. (The insulin order did not contain parameters indicating to hold medication.) Review of the resident's progress notes, dated 05/22/26, showed staff did not document notification of the physician. Review of the resident's May 2026 MAR showed on the morning of 05/24/26, staff did not administer insulin as ordered, blood sugar documented as 83 mg/dL, and staff documented vital signs outside of parameters to be given. (The insulin order did not contain parameters indicating to hold medication.) Review of the resident's progress notes, dated 05/24/26, showed staff did not document notification of the physician. Review of the resident's May 2026 MAR showed on the morning of 05/25/26, staff did not administer insulin as ordered, blood sugar documented as 118 mg/dL, and staff documented vital signs outside of parameters to be given. (The insulin order did not contain parameters indicating to hold medication.) Review of the resident's progress notes, dated 05/25/26, showed staff did not document notification of the physician. Review of the resident's May 2026 MAR showed on the morning of 05/26/26, staff did not administer insulin as ordered, blood sugar documented as 159 mg/dL, and staff documented resident refused. Review of the resident's progress notes, dated 05/26/26, showed staff did not document notification to the physician. Review of the resident's May 2026 MAR showed on the morning of 05/27/26, staff did not administer insulin as ordered, blood sugar documented as 72 mg/dL, and staff documented vital signs outside of parameters to be given. (The insulin order did not contain parameters indicating to hold medication.) Review of the resident's progress notes, dated 05/27/26, showed staff did not document notification of the physician. Review of the resident's current POS showed, on 05/27/26, the previous insulin order discontinued, and a new order, dated 05/27/26, for Lantus subcutaneous solution pen-injector 100 units per ml, inject 42 unit subcutaneously two times a day for diabetes and hold for blood sugar less than 120 mg/dL. Review of the resident's May 2026 MAR showed on the morning of 05/28/26, staff did not administer insulin as ordered, indicated a blood sugar reading of 133 mg/dL, and documented no insulin required. (Order showed to hold medication for blood sugar less than120 mg/dL) Review of the resident's progress notes, dated 05/28/26, showed staff did not document notification of the physician. Review of the resident's May 2026 MAR showed on the evening of 05/28/26, staff did not administer insulin as ordered, indicated a blood sugar reading of 122 mg/dL, and documented no insulin required. (Order showed to hold medication for blood sugar less than 120 mg/dL) Review of the resident's progress notes, dated 05/28/26, showed staff did not document notification of the physician. 3. During interviews on 06/01/26, at 11:21 A.M. and 12:23 P.M., (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Registered Nurse (RN) G said the following:-The nurse should notify the Nurse Practitioner (NP) if a resident refused medications;-The physician should be notified and a progress note initiated if a resident did not receive ordered medication; -Long-acting insulin should not be held without an order;-He/she may hold long-acting insulin if blood sugar is below 100 mg/dL, but would notify the physician;-Staff should follow physician orders. During an interview on 06/01/26, at 2:09 P.M., Certified Medication Technician (CMT) H said he/she would notify the nurse of a resident refusing medication. The nurse will try to administer the medication and if not mark it as a refusal. During an interview on 06/01/26, at 2:36 P.M., Licensed Practical Nurse (LPN) C said nurses should be following physician orders. During an interview on 06/01/26, at 2:52 P.M., RN J said the physician should be notified of a resident's insulin being held. During an interview on 06/01/26, at 3:16 P.M., the Assistant Director of Nursing (ADON) said nurses should make a progress note if insulin is held and indicate why held and notification to the physician. Staff should be following physician orders. During an interview on 06/01/26, at 3:44 P.M., the Director of Nursing (DON) said staff should follow physician orders. During an interview on 06/01/26, at 4:47 P.M., the Administrator said staff should be following physician orders. During an interview on 06/16/26, at 9:22 A.M., the attending physician said staff should not be holding long-acting insulin. He/she should be notified if a blood sugar result was really low and then he/she will decide if it should be held or not. Complaint #3022586

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to establish and maintain a complete infection control program when staff failed to have processes in place to ensure all residents were screened 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 staff failed to complete a two-step test TB test for three residents (Resident #1, #3, and #4). The facility census was 111.Review of the facility policy titled Resident Screening for Tuberculosis, dated October 2025, showed the following:-The facility screens residents for tuberculosis in accordance with the state requirements as part of the overall infection prevention and control program;-Prior to or at the time of admission, all new residents will receive TB screening and testing in accordance with the state requirements;-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 staff, or any licensed physician;-All current residents previously TB test negative will be re-rescreened in accordance with the state requirements;-Nursing staff are responsible for initial and repeat resident screening, documentation of the results, and documentation of any assessments or symptoms of TB disease. Review of the State of Missouri Code of Regulations 19 CSR 20-20.100 showed the following:-Long-term care residents are required to have the initial test of a Mantoux PPD (purified protein derivative - skin test that is used to test for TB) two-step tuberculin test within one month prior to or one week after admission;-If the initial test is negative, zero to nine millimeters (mm), the second test, which can be given after admission, should be given one to three weeks later;-All long-term care facility residents shall have a documented annual evaluation to rule out signs and symptoms of tuberculosis disease. 1. Review of Resident #1's face sheet (a document that gives a resident's information at a quick glance) showed the following:-admission date of 02/05/26;-Diagnoses included chronic obstructive pulmonary disease (COPD-a progressive, incurable lung disease that causes severe breathing difficulties by obstructing airflow, primarily through bronchitis or emphysema), congestive heart failure (CHF - impaired heart function), and diabetes mellitus (metabolic disease). Review of the resident's current Physician's Order Sheet (POS) showed the following orders:-An order, dated 02/05/26, for aplisol solution (TB test solution) 5 units per 0.1milliliters (ml), inject 0.1 ml intradermally (under the skin) one time only for admission, give step one in left arm and record in immunization tab;-An order, dated 02/05/26, to read TB results and record in immunization [NAME] time only for reading step one in left arm;-An order, dated 02/05/26, for aplisol solution 5 units per 0.1 ml, inject 0.1 ml intradermally one time only for admission second step, give step two in right arm and record in immunization tab;-An order, dated 02/05/26, to read TB results and record in immunization [NAME] time only for reading second step in right arm;-An order, dated 02/06/26, for aplisol solution 5 units per 0.1 ml, inject 0.1 ml intradermally one time only for admission second step, give step two in right arm and record in immunization tab;-An order, dated 04/10/26, for aplisol solution 5 units per 0.1ml, inject 0.1 ml intradermally one time only for admission, give step one in left arm and record in immunization tab;-An order dated 04/10/26, to read TB results and record in immunization [NAME] time only for reading step one in left arm;-An order dated 04/10/26, for aplisol solution 5 units per 0.1 ml, inject 0.1 ml intradermally one time only for admission second step, give step two in right arm and record in immunization tab;-An order, dated 04/10/26, to read TB results and record in immunization [NAME] time only for reading second step in right arm. Review of the resident's February 2026 Treatment Administration Record (TAR) showed the following:-An order, dated 02/05/26, for aplisol solution 5 units per 0.1ml, inject 0.1 ml intradermally one time only for admission, give step one in left arm and record in immunization tab, documented as completed;-An order, dated 02/05/26, for aplisol solution 5 units per 0.1 ml, inject 0.1 ml intradermally one time only for admission second step, give step two in right arm and record in immunization tab, not documented as completed;-An order, dated 02/08/26, to read TB results and record in (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	immunization [NAME] time only for reading step one in left arm, documented as completed;-An order, dated 02/12/26, for aplisol solution 5 unit per 0.1 ml, inject 0.1 ml intradermally one time only for admission second step, give step two in right arm and record in Immunization tab, documented as resident sleeping;-An order, dated 02/15/26, to read TB results and record in immunization [NAME] time only for reading second step in right arm, documented as completed. Review of the resident's February 2026 progress notes showed staff did not document related to tuberculosis screening or tuberculosis testing. Review of the resident's April 2026 MAR showed the following:-An order, dated 04/10/26, for aplisol solution 5 units per 0.1 ml, inject 0.1 ml intradermally one time only for admission, give step one in left arm and record in immunization tab, documented as completed;-An order, dated 04/13/26, to read TB results and record in immunization [NAME] time only for reading step one in left arm, documented as completed. Review of the resident's April 2026 progress notes showed staff did not document related to tuberculosis testing. Review of the resident's current immunizations record, reviewed on 05/27/26, showed no entries related to tuberculosis screening or tuberculosis testing. Review of the resident's record showed staff did not have TB results noted. 2. Review of Resident #3's face sheet showed the following:-admission date of 04/30/26;-Diagnoses include COPD and neck cancer. Review of the resident's current POS showed the following orders:-An order, dated 04/30/26, for aplisol solution 5 units per 0.1 ml, inject 0.1 ml intradermally one time only for admission, give step one in left arm and record in immunization tab;-An order, dated 04/30/26, for aplisol solution 5 units per 0.1 ml, inject 0.1 ml intradermally one time only for admission, give step two in right arm and record in immunization tab;-An order, dated 04/30/26, to read TB results and record in immunization [NAME] time only for reading step one in left arm;-An order, dated 04/30/26, to read TB results and record in immunization [NAME] time only for reading second step in right arm;-An order, dated 05/01/26, for aplisol solution 5 units per 0.1 ml, inject 0.1 ml intradermally one time only for admission, give step one in left arm and record in immunization tab;-An order, dated 05/01/26, for aplisol solution 5 units per 0.1 ml, inject 0.1 ml intradermally one time only for admission, give step two in right arm and record in immunization tab. Review of the resident's April 2026 MAR showed the order, dated 04/30/26, for aplisol solution 5 units per 0.1 ml, inject 0.1 ml intradermally one time only for admission, give step one in left arm and record in immunization tab, not documented as completed. Review of the resident's April 2026 progress notes staff did not document related to tuberculosis screening or tuberculosis testing. Review of the resident's May 2026 MAR showed the following:-An order, dated 05/01/26, for aplisol solution 5 units per 0.1 ml, inject 0.1 ml intradermally one time only for admission, give step one in left arm and record in immunization tab, documented as completed;-An order, dated 05/01/26, for aplisol solution 5 units per 0.1 ml, inject 0.1 ml intradermally one time only for admission, give step two in right arm and record in immunization tab, documented as completed on 05/15/26;-An order, dated 04/30/26, to read TB results and record in immunization [NAME] time only for reading step one in left arm, documented as completed on 05/04/26;-An order, dated 04/30/26, to read TB results and record in immunization [NAME] time only for reading second step in right arm, documented as completed on 05/17/26. Review of the resident's May 2026 progress notes showed staff did not document related to tuberculosis screening or tuberculosis testing. Review of the resident's current immunizations record showed an entry dated 05/15/26 for a TB skin test administered. No results were documented. Review of the resident's record showed staff did not have TB results noted. 3. Review of Resident #4's face sheet showed the following:-admission date of 03/04/36;-Diagnoses include stroke and CHF. Review of the resident's current POS showed the following orders:-An order, dated 03/04/26, for aplisol solution 5 units per 0.1 ml, inject 0.1 ml intradermally one time only for admission, give step one in left arm and record in immunization tab;-An order, dated 03/04/26, for aplisol solution 5 units per 0.1 ml, inject 0.1 ml intradermally one time only for admission, give step two in right arm and record in immunization tab;-An order, dated 03/04/26, to read TB results and record in immunization [NAME] time only for reading step one in left arm;-An order, dated 03/04/26, to read TB results and record in immunization (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	[NAME] time only for reading second step in right arm; Review of resident's March 2026 and April 2026 progress notes showed staff did not document related to tuberculosis screening or tuberculosis testing. Review of the resident's current immunizations record showed one entry, dated 03/04/26, for a TB skin test administered with negative results. (Staff did not document a step two test documented as completed with results.) 4. During an interview on 05/28/26, at 1:12 P.M., Licensed Practical Nurse (LPN) C said the following:-An order for a TB test is entered for day of admission for a two-step TB test;-A TB test is done on admission, and another one is done 10 days later;-If there is not enough time to complete the test, he/she will pass it on to the next shift;-Nurses should document the induration (redness or swelling at TB injection site) and if the test was positive or negative when read;-The TB results should be entered into the immunizations tab in the resident electronic chart. During an interview on 05/28/26, at 1:52 P.M., the LPN E said the following:-admission nurse should be completing TB test upon admission;-Residents should receive a two-step TB test;-The nurse should be document results in the immunization tab of the resident electronic chart;-TB result documentation should include where the test was administered on the body, induration, and the result should indicate positive or negative;-Some of the resident TB tests have not been completed. During an interview on 06/01/26, at 11:21 A.M., Registered Nurse (RN) G said the following:-Residents are given a TB test upon admission and then again 10 days later;-If the TB test is not done on the day of admission it might get missed;-It can easily be missed if not done on day of admission;-The oncoming nurse will do the TB test if the admitting nurse does not have time;-A notification on the MAR pops up when it is time to read the test;-The nurse should document the site, the result, and the induration;-He/she was unsure where the results populate on the resident chart. During an interview on 06/01/26, at 2:53 P.M., RN J said the admission nurse should put in the order and complete a TB test. Residents require a two-step TB test upon admission. During an interview on 06/01/26, at 3:16 P.M., the Assistant Director of Nursing (ADON) said the following: -Residents should have a TB test upon admission and nurses should read it 48 to 72 hours later;-The TB test should be completed again a week later;-Nurses should document results in the immunization tab in the electronic medical record;-The results should include induration and result of positive or negative;-The admission nurses are responsible for completing TB tests;-He/she thinks they are getting done but does not know who monitors this. During an interview on 06/01/26, at 3:44 P.M., the Director of Nursing (DON) said the following:-The Staff Development Coordinator was responsible for reviewing TB tests but quit;-There was a problem with TB testing upon admission. During an interview on 06/01/26, at 4:47 P.M., the Administrator said staff should be completing resident TB tests. Complaint #3022586