STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265320	A. Building B. Wing	12/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire Senior Living Carthage	1901 Buena Vista Avenue Carthage, MO 64836

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interviews and record review, the facility failed to ensure allegations of possible abuse were reported immediately to management and within two hours to the State Survey Agency (Department of Health and Senior Services - DHSS) when staff received allegations of possible abuse involving one resident (Resident #1) and failed to report the allegation in a timely fashion. The facility census was 110.Review of the facility's policy titled Abuse and Neglect, revised 04/16/24, showed the following:-The facility is committed to facilitate efforts to protect residents from abuse neglect, misappropriation of residents' property and exploitation;-In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility shall ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of residence property, are reported immediately, but not later than two hours after the allegations is made, if the events that caused the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that caused the allegations do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the state survey agency and adult protective services where state law provides for jurisdiction and long term care facilities in accordance with state law through established procedures. 1. Review of Resident #1"s face sheet (admission data) showed the following:-admission date of 10/21/22;-Diagnoses included acute kidney failure, heart failure, anxiety disorder and major depressive disorder. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated comprehensive assessment instrument completed by facility staff), dated 08/20/25, showed the following:-Cognitive skills intact; -The resident had no behaviors. Review of the resident's care plan, revised 06/13/25, showed the following:-The resident had potential for altered mood state/psychosocial well-being related to depression and anxiety, the resident has a history of abuse;-Encourage and allow the resident to voice feelings and concerns;-Observe for changes in mood;-The resident required behavior management related to fixation on health, misconstrued truth, delusions, and hallucinations. Review of the resident's progress note dated 11/02/25, at 5:37 A.M., showed Licensed Practical Nurse (LPN) A documented the resident was confused and anxious. The resident stated he/she was dying and someone came into his/her room to rape him/her. LPN A talked with the resident to reassure him/her and the resident calmed. (The LPN did not document notifications related to the allegation of possible abuse.) Review of the resident's care plan, dated 11/02/25, showed staff added the resident had a statement of someone coming into his/her room with unwanted sexual intent. Review of the resident's progress note dated 11/03/25, at 2:08 P.M., showed a nurse documented he/she noted the previous shift's nurse note involved possible abuse at approximately 1:50 P.M., The nurse notified the Director of Nursing (DON) immediately.Review of the facility's abuse investigation showed staff initiated the investigation on 11/03/25, at 2:00 P.M. Review of the resident's progress note dated 11/03/25, at 3:19 P.M. showed the former Director of Nursing (DON) documented she and the Administrator met with the resident regarding the previous note documented by the night shift nurse. The resident denied making the reported statement and was adamant that no one had touched or harmed him/her. The resident stated he/she felt safe at the facility. The resident verbalized understanding of how to report any issues or concerns if needed. The resident has a known history of delusions and hallucinations. Staff to continue to monitor and follow the current plan of care. Review of DHSS records showed the facility reported the allegation of possible abuse on 11/03/25, at 4:15 P. M. During an interview on 11/06/25, at 8:00 A.M., LPN A said the following:-Staff should report to the supervisor and the on-call nurse immediately of an allegation of abuse; -The facility should call the state within two hours with an allegation of abuse; -Nurses should notify the DON or on-call nurse with an allegation of abuse;-He/she assessed the resident who said he/she did not remember making the allegation of abuse statement;-He/she did not report the allegation of abuse. During an interview on 11/05/25, at 10:50 A.M. Certified Nurse Aide (CNA) B said the following:-Staff should report to the charge nurse immediately an allegation of abuse; -The facility should call the state within two hours with an allegation of abuse. During an interview on 11/05/25, at 11:15 A.M., the former DON said the following:-Staff should report to their supervisor immediately of an allegation of abuse; -The facility should call the state within two hours with an allegation of abuse;-Staff wrote LPN A up for not reporting the allegation of abuse;-LPN A said he/she did not notify her because the resident did not name anyone, and the resident had not been alone. During an interview on 11/06/25, at 11:45 A.M., the Administrator said the following:-Types of abuse staff should monitor include physical, mental, and sexual;-Staff should protect the resident first and report to the

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observation, interview, and record review, the facility failed to provide care per standards of practice when staff failed to consistently assess and document complete, thorough weekly skin assessments and failed care plan related to skin for three residents (Resident #3, Resident #2, and Resident #4) and when staff applied treatment to skin conditions without physician's orders for two residents (Resident #3 and #4). A sample of six residents were reviewed in a facility with a census of 111. Review of the facility's policy titled Skin Assessment, dated 2024, showed the following:-It is the policy to perform a full body skin assessment as part of the systematic approach to pressure injury prevention and management;-A full body, or head to toe, skin assessment will be conducted by a licensed or registered nurse (RN) upon admission/re-admission, daily for three days, and weekly thereafter. The assessment may also be performed after a change of condition or after any newly identified pressure injury;-Documentation of skin assessment include date and time of the assessment, name and position title, observations (skin conditions, how the resident tolerated the procedure), the type of wound, describe wound (measurements, color, type of tissue in wound bed, drainage, odor, pain, if resident refused the assessment and why, and information as indicated or appropriate. 1. Review of Resident #3's face sheet showed the following:-admission date of 04/25/25;-Diagnoses included Alzheimer's disease, heart failure, and major depressive disorder. Review of resident's current Physician's Order Sheet (POS) showed an order, dated 05/15/25, for staff to apply Eucerin moisturizer to face twice daily for facial rash. Review of the resident's care plan, revised 07/25/25, showed the following:-The resident has potential for skin breakdown for skin fragility;-Staff to conduct a skin audit per schedule. (Staff did not care plan regarding a facial rash) Review of the resident's physician progress note imported 08/01/25, at 6:13 A.M., for service date of 07/30/25, showed the physician documented the following:-The resident seen for follow-up of lower extremity cellulitis (infection) and edema (swelling). Diagnosis of cellulitis and atopic dermatitis;-Chronic ulcerations to lower extremities;-Treatment plan included cellulitis, bilateral lower extremities-symptomatically resolved;-Eczematous dermatitis-rash resolved;-Continue Eucerin as needed. Review of resident's current POS showed an order, dated 08/04/25, for staff to conduct weekly skin audit/ Staff to chart a zero for no new skin issues and chart a number one for new skin issues and follow up in nurses' notes. Review of the resident's progress notes and Treatment Administration Record (TAR), dated 08/04/25 through 09/06/25, showed staff did not complete a weekly skin audit with a zero or number one for the resident. Review of the resident's skin assessment on 9/07/25, at 11:50 P.M., showed Licensed Practical Nurse (LPN) E/Wound Nurse documented the resident noted to have 2 plus pitting edema (moderate level of swelling) to bilateral lower extremities. Additionally, patchy, red, raised areas observed on the medial (inner) aspects of his/her bilateral thighs. The resident has a history of cellulitis. Charge nurse notified the primary care physician regarding current skin condition and assessment findings. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's current POS showed an order, dated 09/08/25 with an end date of 09/10/25, for cefdinir (antibiotic) 300 mg capsule twice a day for local infection of the skin and subcutaneous tissue. Review of the resident's nurse's note dated 09/08/25, at 2:21 A.M., showed a nurse documented antibiotic charting for cellulitis. The resident continued antibiotic charting with no signs or symptoms of adverse reactions such as a rash. Review of the resident's nurse's note dated 09/08/25, at 4:03 P.M. showed LPN E/Wound Nurse documented the resident had two episodes of cellulitis related to bilateral lower extremities. Review of the resident's nurse's note dated 09/08/25, at 4:17 P.M., showed a nurse documented antibiotic charting for cellulitis. The resident continued antibiotics. No signs or symptoms of adverse reactions such as a rash. Review of the resident's nurse's note dated 09/09/25, at 3:22 A.M., showed a nurse documented antibiotic charting for cellulitis. The resident continued antibiotic charting with no signs or symptoms of adverse reactions such as a rash. Review of the resident's nurse's note dated 09/09/25, at 1:22 P.M. showed a nurse documented antibiotic charting for cellulitis. The resident continued antibiotics, with no signs or symptoms of adverse reactions such as a rash. The resident has some redness and plus 3 non pitting edema (significant swelling) noted to lower left extremities Review of the resident's nurse's note dated 09/10/25, at 5:53 A.M., showed a nurse documented antibiotic charting for cellulitis. The resident continued antibiotics. The resident has non pitting edema noted to LLE. Review of the resident's current POS showed an order, dated 09/10/25 with an end date of 09/17/25, for amoxicillin (antibiotic) one tablet twice a day for local infection of the skin and subcutaneous tissue. Review of the resident's nurse's note dated 09/11/25, at 2:10 A.M., showed a nurse documented antibiotic charting for cellulitis. The resident continued antibiotics. The resident's LLE was warm to touch and edematous. Review of the resident's nurse's note dated 09/12/25, at 2:21 A.M., showed a nurse documented antibiotic charting for cellulitis. The resident continued antibiotic charting with no signs or symptoms of adverse reactions such as a rash. The resident's left leg was elevated with redness and swelling noted. Review of the resident's physician note imported 09/12/25, at 9:26 A.M., for a service date of 09/10/25, showed the physician documented facility staff reported increased edema and redness to the resident's left lower extremity. Review of the resident's nurse's note dated 09/13/25, at 2:40 A.M showed a nurse documented antibiotic charting for cellulitis. The resident continuec antibiotic charting with no signs or symptoms of adverse reactions such as a rash. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's quarterly MDS assessment, dated 09/13/25, showed the following:-Severely impaired cognitive skills;-At risk for pressure ulcers;-Open lesions other than ulcer, rashes, cuts not marked. Review of the resident's nurse's note dated 09/14/25 ,at 11:05 P.M. showed a nurse documented the resident continued on antibiotic therapy for cellulitis to left lower extremities. The resident's leg remained swollen. Review of the resident's nurse's note dated 09/15/25, at 1:48 P.M., showed a nurse documented antibiotic charting for cellulitis. The resident continued antibiotic with no signs or symptoms of adverse reactions reported. Review of the resident's nurse's note dated 09/16/25, at 2:04 P.M., showed a nurse documented antibiotic charting for cellulitis. The resident continued antibiotic with no signs or symptoms of adverse reactions reported. Review of the resident's progress notes and TAR, dated 09/08/25 through 09/16/25, showed staff did not complete a weekly skin audit with a zero or number one for the resident. Staff did not document a full assessment/description of the resident's skin. Review of the resident's nurse's note dated 09/17/25, at 3:46 A.M., showed a nurse documented antibiotic charting for cellulitis. The resident continued antibiotic charting with no signs or symptoms of adverse reactions such as a rash. Review of the wound nurse note dated 09/17/25, at 9:20 A.M., showed LPN E/Wound Nurse documented the resident's wound site was fully healed upon assessment. The resident's skin was intact with complete epithelialization (new tissue) over the previous wound area. The resident's skin appeared healthy with no signs of active infection, despite treatment for cellulitis. Review of the resident's physician progress note imported 09/18/25, at 7:00 A.M., for service date of 09/17/25 showed the physician documented follow up visit for the resident's left lower extremity cellulitis. Facility nursing staff report swelling to the resident's left leg as resolved and redness much improved. Review of the resident's progress notes and treatment administration record, dated 09/18/25 through 09/29/25, showed staff did not complete a weekly skin audit with a zero or the number one for the resident. Review of the resident's nurse's note dated 09/21/25, at 12:36 A.M. showed a nurse documented the resident continued antibiotic therapy for left lower extremity cellulitis. No signs or symptoms of adverse reaction. Review of the wound nurse note dated 09/30/25, at 11:19 A.M. showed LPN E/Wound Nurse documented new report of skin issue to bilateral lower extremities. Resident noted to have two plus pitting edema to bilateral lower extremities, with an open area related to edema and fluid accumulation. It is noted that the edema is not a new concern. Medical Director to refer the resident to cardiology for further assessment and treatment. (The LPN did not document a full assessment and description of the area.) (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's progress note dated 10/09/25, at 8:32 P.M. showed a nurse documented the resident had no new open areas or skin issues. Review of the resident's progress note dated 10/11/25, at 5:22 A.M. showed a nurse documented the resident had no new open areas or skin issues. Review of the resident's progress note dated 10/13/25, at 5:15 P.M. showed a nurse documented the resident had no new open areas or skin issues. Review of the resident's progress note dated 10/15/25, at 5:06 P.M. showed a nurse documented the resident had no new open areas or skin issues. Review of the resident's nurses note dated 10/18/25, at 6:32 A.M. showed a nurse documented the resident's left arm swollen with pitting plus two edema. Staff notified the physician and awaited instructions. (Staff did not document a full assessment or description.) Review of the current POS showed an order, dated 10/19/25 with end date of 10/25/25, for cephalexin capsule 500 mg one tablet three times a day for cellulitis of left lower limb. Review of the resident's nurse's note dated 10/20/25, at 1:51 P.M., showed a nurse documented the resident continued antibiotic related to cellulitis of his/her left arm. No signs or symptoms of adverse reaction reported. Review of the resident's nurse's note dated 10/21/25, at 2:23 A.M., showed a nurse documented antibiotic charting for left arm cellulitis. The resident continued antibiotic for his/her left arm cellulitis. No signs or symptoms of adverse reactions such as a rash. The resident's left arm swelling and redness improved. Review of the resident's nurse's note dated 10/22/25, at 12:39 A.M., showed a nurse documented antibiotic charting for left arm cellulitis. The resident continued on antibiotics. Review of the resident's nurse's note dated 10/22/25, at 2:01 P.M. showed a nurse documented the resident continues on an antibiotic related to cellulitis of his/her left arm. No signs or symptoms of adverse reactions reported. Review of the resident's nurse's note dated 10/22/25, at 4:11 P.M., showed the former Director of Nursing (DON) documented the physician rounded on this day. New orders received to apply Eucerin topically to left upper extremity two times per day for eczematous dermatitis. Review of resident's current POS showed an order, dated 10/22/25, for staff to apply Eucerin cream twice a day, for rash and other nonspecific skin eruption. Review of the resident's nurse's note dated 10/23/25, at 1:36 A.M,. showed a nurse documented antibiotic charting for left arm cellulitis. The resident continued antibiotics. The resident's left arm is reddened in color with no drainage noted. Review of the resident's nurse's note dated 10/23/25, at 11:17 A.M., showed a nurse documented the resident continued antibiotic for signs and symptoms of cellulitis to his/her left arm. No signs or symptoms of adverse reactions such as a rash. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's nurse's note dated 10/24/25, at 12:09 P.M., showed a nurse documented the resident continued antibiotic for signs and symptoms of cellulitis to the left arm. No signs or symptoms of adverse reactions such as a rash. Review of the resident's nurse note dated 10/25/25, at 1:37 A.M., showed a nurse documented the resident on an antibiotic for left arm cellulitis with no signs or symptoms of adverse reactions such as a rash. Review of the resident's nurses note dated 10/26/25, at 9:57 A.M., showed a nurse documented the resident completed an antibiotic for cellulitis to his/her left arm, no signs of a rash. the resident's left arm had improved. Review of the resident's nurses note dated 10/28/25, at 1:12 A.M., showed a nurse documented the resident was on an antibiotic for his/her left arm cellulitis. No signs or symptoms of adverse reactions such as a rash. Review of the resident's nurses dated 10/29/25, at 1:24 A.M., showed a nurse documented antibiotic charting for left arm cellulitis. No signs or symptoms of adverse reactions such as a rash. Review of the resident's progress notes and TAR, dated 10/18/25 through 10/30/25, showed staff did not complete a weekly skin audit or document a zero or the number one for the resident. Staff did not document a full assessment and description of the resident's skin. Review of the wound nurse note dated 10/31/25, at 8:52 A.M., showed LPN E/wound nurse documented the resident's bilateral lower extremities had declined significantly. Review of the resident's current POS showed an order, dated 11/01/25 with an end date of 11/06/25, for cephalexin capsule 500 mg three times a day for local infection of the skin and subcutaneous tissue. Review of the resident's nurse's note dated 11/02/25, at 12:55 A.M., showed a nurse documented the resident on an antibiotic for lower extremity cellulitis. No signs or symptoms of adverse reactions such as a rash. Review of the resident's nurse's note dated 11/02/25, at 6:51 P.M., showed a nurse documented the resident continued antibiotic charting for cellulitis to the lower extremities. Review of the resident's nurses note dated 11/03/25, at 11:26 A.M. showed a nurse documented the resident continued an antibiotic related to lower extremity cellulitis. No signs or symptoms of adverse reaction noted such as a rash. Review of the resident's nurses note dated 11/03/25, at 12:42 A.M. showed a nurse documented the resident on an antibiotic for lower extremity cellulitis. No signs or symptoms of adverse reactions such as a rash. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's nurses note dated 11/03/25, at 5:24 P.M., showed LPN E/Wound Nurse documented the resident had itching to his/her lower extremities and did not keep the dressings on and caused the ulcerations to bleed. He/she notified the primary care physician with new orders received for Claritin (antihistamine) 10 mg every day. Review of the resident's nurses note dated 11/04/25, at 2:35 A.M. showed a nurse documented the resident continued an antibiotic for lower extremity cellulitis. The resident had no signs or symptoms of adverse reaction such as a rash. Review of the resident's nurses' notes dated 11/04/25, at 7:58 P.M., showed a nurse documented the resident continued antibiotic charting for cellulitis to the lower legs. Review of the resident's nurses' notes dated 11/05/25, at 2:57 A.M., showed a nurse documented the resident continued antibiotic therapy for cellulitis to his/her lower extremities. The resident had Tubi grips (a multi-purpose, elasticated tubular bandage providing continuous support for strains, sprains, swelling, and soft tissue injuries) in place to his/her left leg with no edema. The resident's skin appeared to have been scratched and bled. Review of the resident's nurses' notes dated 11/05/25, at 1:34 P.M. showed a nurse documented the resident continued Keflex (cephalexin) three time a day for lower extremity cellulitis. The nurse documented the resident had no signs or symptoms of adverse reactions noted to treatment. The resident had no abnormal rash or hives. Review of the resident's nurses note dated 11/05/25, at 5:19 P.M. showed LPN E/Wound Nurse documented the resident continued to present with a rash that appeared generalized and scattered throughout the trunk, bilateral upper extremities, and proximal bilateral lower extremities. Characteristics of the rash included red/maroon, railed papular clusters. Surrounding skin noted to be dry. Associated symptoms include itching, no drainage, heat or odor observed. Resident started on Claritin 10 mg daily for itching on 11/03/25. Staff changed the resident's shower soap, and the primary care physician is aware. Wound care physician to evaluate the rash on 11/10/25. Observation on 11/06/25, at 10:47 A.M., showed the resident was scratching him/herself behind his/her left shoulder. The resident had a red rash on his/her stomach, and it was reddened in the middle of his/her back and on the back of the left and right arm. The resident wore a long-sleeved shirt and long pants. During an interview on 11/06/25 at 10:47 A.M., Nurse Aide (NA) G said the resident also had a rash on his/her thighs and behind the knees. They put antifungal cream on the rash. All residents admitted to the facility usually admitted to the 100 hall before they might place them on the unit since they have to know where to place a resident. He/she thought the resident had a rash on the back of his/her right arm when he/she came to live on the unit. During interview on 11/06/25, at 10:41 A.M., NA F who worked on the memory care unit 500 hall, said the following:-They think the rash all over his/her back, both arms with the left arm worse, slight rash on the right arm, both legs and spots on his/her stomach was a fungus;-Both NA F and NA G put antifungal cream on the resident's rash which was itching on his/her left shoulder;-They keep the antifungal cream there on the unit;-He/she thought the resident had a rash on the back of his/her arm when he/she moved there on the unit. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 11/06/25, at 10:47 A.M. showed a tube of 1% Clotrimazole Cream Antifungal cream in the resident's room drawer. Review of the resident's physician's orders dated 08/01/25 to 11/06/25, showed staff did not document an order for an antifungal cream to put on the resident's skin. During an interview on 11/06/25, at 2:38 P.M., LPN E/Wound Nurse said today (11/06/25) the resident had a clustered type of rash on his/her thigh. Staff treated the resident for itching. The resident's weekly skin assessment should had shown a rash. During an interview on 11/06/25, at 4:05 P.M. the MDS/Care Plan Coordinator said she was not aware of the resident's rash, and it should be on the resident's care plan. 2. Review of Resident #2's face sheet showed the following:-admission date of 06/06/25;-Diagnoses included orthopedic aftercare following surgical amputation, acquired absence of left leg above knee, high blood sugar, congestive heart failure, high blood pressure, cellulitis (bacterial skin infection that causes red, swollen, warm, and painful skin that spreads quickly) of face. Review of the resident's quarterly MDS, dated [DATE], showed the following:-Cognitive skills intact;-At risk for pressure ulcers;-Open lesions other than ulcer, rashes, cuts not marked. Review of the resident's care plan, edited 9/10/25, showed the following:-Staff may apply moisture barrier to skin and provide incontinence care after each incontinent episode.(Staff did not care plan regarding monitoring the resident's skin for pressure ulcers, skin rashes, and cuts.) Review of the resident's progress notes, dated 09/24/25 to 10/01/25, showed the staff were to document antibiotic charting for cellulitis of the resident's nose. Review of the resident's progress notes showed the following:-On 9/24/25, the resident was on antibiotic charting for cellulitis to nose. There was no adverse effect such as rash noted;-On 9/25/25, showed the physician saw the resident and gave new orders for Rocephin (antibiotic for bacterial infection)1 gram (gm) Intramuscular (IM) for five days and doxycycline (antibiotic used for skin infections)100 milligrams (mg) for 10 days for cellulitis of the face; -On 9/26/25, showed the resident continued antibiotic with no signs/symptoms of adverse reactions. No reported rash. The nose was red and swollen;-On 9/27/25, showed the resident continued antibiotic with no signs/symptoms of adverse reactions. No reported rash. The nose was red and swollen;-On 9/30/25, showed the resident continued antibiotic with no signs/symptoms of adverse reactions. No reported rash. The nose was slightly red and no swelling;-On 10/01/25, showed the resident continued antibiotic with no signs/symptoms of adverse reactions. No reported rash. The nose was slightly red and no swelling:-On 10/03/25, showed the resident continued antibiotic with no signs/symptoms of adverse reactions. No reported rash. The nose was much normal in appearance, mild swelling and no redness;-On 10/04/25, showed the resident continued doxycycline 100mg twice a day until 10/6/25 for cellulitis to nose. Nose normal in appearance. No adverse reaction notes to antibiotic therapy, no rash. Review of the resident's progress note, dated 10/09/25, showed the physician saw the resident and gave new orders for prednisone (steroid) 20 mg every day for seven days and then 10mg every day for 7 days and then to stop. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265320	A. Building B. Wing	12/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire Senior Living Carthage	1901 Buena Vista Avenue Carthage, MO 64836

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's Medications Administration History, dated 10/10/25 to10/16/25, showed a physician's order for prednisone tablet 20mg to administer one tablet for seven days, then stop for contact dermatitis (an inflamed skin reaction that causes an itchy, red, and sometimes bumpy or blistered rash when the skin touched an irritant or allergen). Staff administered the prednisone to the resident from 10/10/25 to 10/16/25. Review of the resident's Medications Administration History, dated 10/17/25 to 10/23/25, showed a physician's order for prednisone tablet 10mg to administer one tablet for seven days, then stop for contact dermatitis. Staff administered the prednisone from 10/17/25 to 10/23/25. Review of the resident's POS, dated 08/01/25 to 11/06/25, showed staff were to do a weekly skin audit and to record 0 for no new skin problems, 1 for new skin problems and follow up in the notes once a day every Saturday. Review of the resident's medical record showed there were no notes regarding a weekly skin audit for 08/01/25 to 11/05/25. Review of the resident's progress notes, dated 10/9/25 to 11/4/25, showed staff did not document any issues with the resident's skin for a non-specific rash. Review of the resident's progress note, dated 11/05/25, showed the wound care nurse documented the resident continued to present with a persistent rash. Multiple interventions had been attempted without noted improvement. The physician was aware of the ongoing issue. The wound care physician visit was scheduled for 11/10/25 and they were to evaluate the rash at that time. Observation on 11/05/25, at 11:45 A.M., showed the resident sat in the wheelchair in his/her room. The bedsheets had spots of blood. There were dark scabs and pimple-like red sores on the resident's outer arms. The resident began scratching him/herself at times on arms and stomach.During interview on 11/05/25, at 11:45 A.M., the resident said the following:-He/she had a rash on his/her upper back, thighs, arms, groin, stomach, and buttocks;-The physician had looked at it and gave him/her steroid medication and said it was a form of dermatitis;-He/she had this rash for the past three weeks. He/she had taken a shower and the rash came back. He/she thinks the rash is bacterial and activated by heat;-Staff had washed his/her bed sheets together with other residents' bed sheets and linens. He/she did not want his/her bed sheets washed frequently;-When he/she was on the 100 hall, he/she got a rash for three days from taking penicillin (an antibiotic). He/she used Benadryl (antihistamine for itching) cream and did take a Benadryl pill at night;-He/she was to see the physician tomorrow. He/she said his/her belly really itches and was scratching him/herself. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview on 11/06/25, at 2:10 P.M., the resident's physician said the following:-The rash was scabies since it was all over and looked like the classic scabies;-Before, the rash was more diffuse but now it looked like scabies. It looked better but it was more spotted;-The resident had a sore in his/her nose and it got worse and turned into cellulitis in his/her face. At the time, the resident had an all over rash and thought he/she had contact dermatitis from possible laundry soap, or bath soap and they did change the soaps;-He put the resident on steroids for this;-Staff did not call him/her about the change in the rash until today, but had put the resident on Prednisone for seven days in October;-He would have liked to have been called when the resident finished the Prednisone;-He would prescribe Permethrin and Invermectin now for the resident;-Scabies broke out on the 500 hall unit and they did treat all the residents on the hall at one time;-They would isolate Resident #2 for at least a week and possibly treat the roommate;-Sometimes the test to scrape for scabies is sometimes negative result. They did try to get someone to come to the facility and do the scraping, but they did not come. 3. Review of Resident #4's face sheet showed the following:-admission date of 01/28/25;-Diagnoses included dementia without behavioral disturbance, local infection of the skin and subcutaneous tissue, pruritus (itchy skin), rash and other nonspecific skin eruption, dermatitis. Review of the resident's quarterly MDS, dated [DATE], showed the following:-Severely impaired cognition;-At risk for pressure ulcers;-Open lesions other than ulcer, rashes, cuts not marked. Review of the resident's care plan, dated 02/07/25 and edited 10/27/25, showed the following:-Potential for skin breakdown, skin tears, bruises related to self-ambulatory, confusion/forgetfulness, and skin fragility;-Approaches included inspect skin for changes daily. Review of the resident's physician's orders, dated 07/02/25 to 08/13/25, showed an order for Ivermectin (prescription medication used to treat scabies) 3 mg three tablets (9 mg) by mouth once a day on Wednesday for dermatitis. Review of the resident's progress notes dated 08/06/25, showed LPN E/Wound Nurse, documented that nursing staff reported the resident had a rash. The resident had been previously evaluated by the physician and had received multiple treatments for the rash. This was not a new occurrence, and the rash had already been addressed with appropriate interventions. The resident was treated with oral Ivermectin and topical permethrin. The physician followed up with resident on 07/29/25 and the resident reported to the physician that he/she did not have any scratching since treatment, and resolved out rash. The condition will continue to be monitored for any changes or worsening condition. Review of the resident's progress notes, for service date 08/20/25, showed the following:-Chief complaint of rash;-The resident was seen today at request of facility staff for recurrence of diffuse rash with itching. Patient reports itching and redness to arms, legs, chest, and back. He/she resides on the memory care unit. No new lotions, soaps or medications reported;-Skin: diffuse popular erythematous rash;-Rash-suspect recurrence of scabies. Ivermectin PO (by mouth) now and Permethrin topically. Will repeat in one week. Review of the resident's physician's orders, dated 08/21/25, showed an order of Ivermectin 3 mg, three tablets (9mg) by mouth, One Time Dose. Review of the resident's physician's orders, dated 08/21/25 to 08/29/25, showed an order of Permethrin (medicated skin cream for scabies) cream 5%, thin layer, topical, One Dose, once a day on Thursday. Review of the resident's Medications Administration History, dated 08/01/25 to 08/31/25, showed staff administered the permethrin medicated cream on 08/21/25. Review of the resident's Medications Administration History, dated 08/01/25 to 08/31/25, showed staff did not administer the permethrin cream on 08/28/25 because the drug/item was unavailable. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's physician's orders, dated 08/23/25 to 09/02/25, showed an order for Contact Isolation precautions every shift. Review of the resident's progress notes showed the following:-On 08/23/25, staff documented there was no new open areas or skin issues;-On 8/24/25, staff documented Infection Control: Isolation type Contact, Resident continued contact isolation due to rash;-On 08/26/25, staff documented the resident continued contact isolation. Resident compliant with isolation. Review of the resident's progress note, for 08/27/25 service date, showed the Nurse Practitioner (NP) documented the following:-Chief Complaint: Follow-up of rash;-Patient was seen today for follow-up of rash. Patient reports itching and redness to arms, leg, chest, and back much improved;-Skin: resolving diffuse popular erythematous rash;-Treatment Plan: Rash-symptomatically improved. Continue Permethrin topically as ordered. Review of the resident's progress notes, dated 08/30/25, showed staff documented the resident continues on contact isolation. Review of the resident's progress notes, dated 10/07/25 for service date of 10/1/25 with the NP, showed the resident's skin was normal. Review of the resident's physician order report, dated 01/08/25, showed staff were to do a weekly skin audit and to record 0 for no new skin problems, 1 for new skin problems and follow up in the notes once a day on Wednesday. Review of the resident's Medication Administration Record and the Treatment Administration Record, dated 08/01/25 to 11/05/25, showed staff did not document regarding a skin audit of the resident. Review of the resident's progress notes from 08/27/25 through 11/04/25 showed no documentation of the resident's skin and/or the rash. Review of the resident's progress note, dated 11/05/25, showed LPN E/Wound Nurse showed the resident continued to present with a persistent rash. Multiple interventions have been attempted without noted improvement. The physician was aware of the ongoing issue. Confirmation received for the wound care physician visit scheduled for 11/10/25. The resident to be evaluated for rash at that time. During interview on 11/06/25, at 10:41 A.M., Nurse Aide (NA) F who worked on the memory care unit 500 hall, said the following:-They monitor the resident's skin when they give them a shower, change their clothes, provide incontinence care, and take them to the restroom;-They report anything on the skin such as bruising and rashes to the nurse at the nursing desk;-The resident had a rash all over his/her body;-They put an antifungal cream and extra lotion on the resident's skin, and it was better; -The resident was itching and mainly complaine