

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265407	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2025
NAME OF PROVIDER OR SUPPLIER Aspire Senior Living Moberly		STREET ADDRESS, CITY, STATE, ZIP CODE 700 East Urbandale Drive Moberly, MO 65270	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>35615</p> <p>Based on interview and record review, the facility failed to ensure medication was administered according to professional standards of practice for one resident (Resident #1), in a review of five sampled residents. Licensed Practical Nurse (LPN) A administered an antipsychotic medication prepared by another nurse, LPN D, was unaware of the contents of the medication cup when he/she administered the medication to the resident and failed to document administration of the medication. LPN D gave a certified nurse aide medication LPN D prepared and when the certified nurse aide was unsuccessful in administration, LPN A administered the medication. The facility census was 64.</p> <p>Review of the facility undated Medication Administration policy showed the following:</p> <ul style="list-style-type: none"> -Medications are administered by licensed nurses, or other staff who are legally authorized to do so, as ordered by the physician and in accordance with professional standards of practice; -Review Medication Administration Record (MAR) to identify medication to be administered; -Compare medication source with MAR to verify resident name, medication name, form, dose, route, and time; -Remove medication from source; -Administer medication as ordered, provide appropriate amount of food and fluid, crush medication s as ordered; -Observe resident consumption of medication; -Sign MAR after administered; -Report and document any adverse side effects or refusals. <p>Review of dhss.mo.gov Certified Nurse Assistant (CNA) registry website showed the CNA training program prepares individuals for employment in a long-term care facility. The program teaches skills in resident care under the direct supervision of a licensed nurse and does not include medication administration by the CNA.</p> <p>(continued on next page)</p>

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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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>1. Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument, completed by facility staff, dated 2/13/25, showed the following:</p> <ul style="list-style-type: none"> -Severe cognitive impairment; -No delusions or hallucinations; -No physical or verbal behaviors towards others; -Other behavioral symptoms not directed toward others occurred (symptoms such as hitting or scratching self, pacing, rummaging, disrobing in public, verbal or vocal symptoms like screaming or disruptive sounds); -Required antianxiety medications during the previous seven days; -No antipsychotic medications required. <p>Review of the resident's Care Plan, dated 2/17/25, showed the following:</p> <ul style="list-style-type: none"> -Diagnoses of Parkinson's disease (a progressive neurological disease that caused decline in mobility, movement and cognitive ability), adjustment disorder with mixed anxiety and depressed mood, dementia with agitation, anxiety disorder, and mood disorder; -The resident was forgetful and confused with anxiety and agitation at times related to dementia. He/She could be resistive and agitated during care. Behaviors appeared to be worse in the late afternoon-evenings. Staff should not confront or argue with the resident, attempt to interest in diversional activity. Approach in calm manner. If unable to calm the resident and he/she remained resistive to care, assure a safe environment and allow the resident to calm down, reapproach later. If the resident refused medication when upset, reapproach when the resident was calm, have a different nurse/medication technician offer medications. <p>Review of the resident's Nurses Note, dated 2/17/25, showed staff documented at 6:47 P.M. the resident continued to yell out for family and for help. Staff redirected and sat with the resident. Physician notified and one time order for Trazadone (medication in the treatment of major depressive disorder) 25 milligrams (mg) received.</p> <p>Review of the resident's Physician Order Sheets (POS), dated 2/17/25, showed Trazadone 25 mg one time only for anxiety and yelling out.</p> <p>Review of the resident 's Medication Administration Record (MAR), dated 2/17/25, showed at 6:24 P.M., staff documented administration of Trazadone 25 mg, one time only.</p> <p>Review of the resident's record showed no documentation regarding the resident's condition, behaviors or effectiveness of Trazadone 25 mg administered on 2/17/25 at 6:24 P.M.</p> <p>Review of the resident's POS, dated 2/18/25, showed Zyprexa (antipsychotic medication used to treat mental illness) 2.5 mg every 12 hours as needed for anxiety.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the resident's Nurses Notes showed staff did not document the resident's condition or behaviors regarding the physician's orders on 2/18/25 for Zyprexa 2.5 mg every 12 hours as needed for anxiety.</p> <p>Review of the resident's MAR showed staff documented on 2/18/25 at 7:11 P.M., Zyprexa 2.5 mg administered as needed for anxiety.</p> <p>Review of the resident's Nurses Note, dated 2/18/25 at 9:24 P.M., showed staff documented Zyprexa 2.5 mg administered at 7:11 P.M. and was ineffective.</p> <p>Review of the resident's MAR showed staff documented on 2/19/25 at 8:18 A.M. Zyprexa 2.5 mg administered as needed for anxiety.</p> <p>Review of the resident's Nurses Notes showed no staff documentation regarding the resident's condition or behaviors regarding administration of Zyprexa 2.5 mg at 8:18 A.M.</p> <p>Review of the resident's Nurses note, dated 2/18/25 at 9:47 A.M., showed staff documented Zyprexa 2.5 mg administered at 8:18 A.M. and was effective.</p> <p>During an interview on 2/27/25 at 10:20 A.M., Licensed Practical Nurse (LPN) D said the resident was frequently agitated and refused medication. Recent medication changes were made. On 2/19/25 at about 6:00 P.M., the resident was agitated and refused medications. LPN D obtained the resident's as needed Zyprexa medication and mixed the medication in applesauce. The resident refused the medication. LPN D gave Certified Nurse Assistant (CNA) C the cup of Zyprexa and applesauce to administer, and the resident refused. LPN A was at the desk for change of shift report and said he/she would administer the medication. LPN A took the cup of Zyprexa and applesauce. LPN D went down the hall to attend another resident. When LPN D returned, LPN A said he/she administered the resident's Zyprexa and applesauce. LPN D did not document Zyprexa 2.5 mg had been administered on the resident's MAR. LPN A should have documented Zyprexa 2.5 mg administered on the resident's MAR.</p> <p>Review of the resident's MAR, dated 2/19/25, showed no documentation staff administered Zyprexa 2.5 mg at approximately 6:00 P.M.</p> <p>Review of the resident's record showed no staff documentation regarding the resident's condition or behaviors regarding administration of Zyprexa 2.5 mg at approximately 6:00 P.M. and no staff documentation regarding the effectiveness of the medication.</p> <p>During an interview on 2/27/25 at 1:45 P.M., LPN A said on 2/19/25 at about 6:00 P.M., he/she came to work and the resident was agitated. Certified Medication Technician (CMT) G handed LPN A a medication cup of applesauce and asked LPN A to administer the medication in the cup. LPN A did not know what medication was in the medication cup, never saw who prepared the medication, and did not document any as needed medication as administered on 2/19/25 at about 6:00 P.M. LPN A did not know the medication cup contained Zyprexa mixed in applesauce.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/27/25 at 4:00 P.M., the Director of Nursing said the same staff who prepared a medication should administer the medication and document administration of the medication. Staff should document in the resident's nurses' notes behaviors and communication with physicians regarding behaviors and new physician orders. Staff should not pass a prepared medication cup from one nurse to another for administration. Only licensed nurses and CMT staff were allowed to administer medications. CNA staff were not allowed to administer medications. The resident had behaviors. Staff should follow the facility policy regarding medication administration.</p> <p>During an interview on 3/12/25 at 11:20 A.M., the Administrator said staff should assess and document the resident's condition and behaviors before and after any as needed medication was administered. Staff should follow the facility medication administration policy and the nurse that prepared a medication should administer the medication to ensure accuracy. Staff should document in the resident's MAR all medications administered. If a medication was not given, staff should document in the MAR and nurses' notes the reason the medication was not given.</p>		