STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265407	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire Senior Living Moberly	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)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to administer medications per physician's order, manufacturer guidelines, and per professional standard of practice for four additional residents (Residents #80 #32, #59, and #54), and failed to provide proper care for a urinary catheter (tube inserted into the bladder to drain urine) for one resident (Resident #7). The facility census was 71. Review of the facility policy, Medication Administration, dated 10/01/25, showed the following:-Medications are administered by licensed nurses or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection;-Administer medication as ordered in accordance with manufacturer specifications (provide appropriate amount of food and fluid). 1. Review of Resident #80's physician's orders, dated May 2026, showed the following:-His/Her diagnoses included hypokalemia (low potassium);-Potassium chloride (nutritional supplement) 10%, 20 milliequivalents (meq) per 15 milliliters (ml); administer 7.5 ml orally two times a day for treatment of hypokalemia (low potassium levels);-Dilute every 15 ml in 3-ounces of liquid. Review of the potassium chloride suspension bottle showed it directed staff to dilute the medication prior to administration. Observation on 05/19/26 at 9:37 A.M. showed Certified Medication Technician (CMT) J removed 7.5 ml of potassium chloride and administered it to the resident without diluting the medication in liquid as ordered. During an interview on 05/21/26 at 11:20 A.M., CMT J said he/she thought the potassium chloride was already diluted so he/she did not know he/she was to dilute it prior to administration. 2. Review of the facility policy, Administration of Metered-Dose Inhalers, dated 10/01/25, showed if using a corticosteroid (an anti-inflammatory steroid medication), allow the resident to rinse and gargle with water if desired, to remove medication from the mouth and back of throat. Review of Resident #32's significant change Minimum Data Set (MDS, a federally mandated assessment instrument required to be completed by facility staff), dated 03/04/26, showed the following: -His/Her cognition was severely impaired;-His/Her diagnoses included chronic lung disease. Review of the resident's physician's orders, dated May 2026, showed an order for a Combivent inhaler (steroid inhaler used with treatment of chronic lung diseases), one puff inhaled four times a day. Rinse mouth and spit after each use. Observation on 05/19/26 at 4:22 P.M. showed CMT J assisted the resident to administer the Combivent inhaler. The resident inhaled the medication as ordered. CMT J provided the resident with a cup of water, and the resident took a drink. CMT J did not instruct the resident to rinse his/her mouth with the water and spit. During an interview on 05/21/26 at 11:20 A.M., CMT J said residents were to rinse their mouth by swishing water and spitting after using an inhaler. Staff needed to instruct the resident to swish and spit. He/She did not realize he/she did not instruct the resident to swish and spit after the resident used the inhaler. During an interview on 05/21/26 at 4:30 P.M., the Director of Nursing said staff should administer medications as ordered and per professional standards of care. Staff should instruct residents to rinse their mouths after using an inhaler if they were directed to do so. 3. Review of Resident #59's physician order sheet (POS), dated May 2026, showed the following:-The resident had an order for Novolog (fast-acting insulin) FlexPen four times a day; -The fast-acting insulin was ordered to be administered according to the resident's blood sugar (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	level; -0-150 blood sugar, administer no insulin; -151-200 blood sugar, administer 2 units of insulin; -201-250 blood sugar, administer 4 units of insulin; -251-300 blood sugar, administer 6 units of insulin; -301-350 blood sugar, administer 8 units of insulin; -351-400 blood sugar, administer 10 units of insulin; -Call the resident's physician if blood sugar is over 400. Review of NovoLog.com, specific instructions for the Novolog FlexPen showed the following: -Inject the needle into the skin and hold the push button in all the way;-Continue holding the push button and keep the needle under the skin for six seconds. Observation on 5/20/26 at 7:08 A.M. showed the following:-Licensed Practical Nurse (LPN) K primed the insulin pen with 2 units of insulin;-LPN K prepped the skin on the resident's right lower abdomen, injected the needle under the skin and administered the ordered 2 units of insulin;-LPN K immediately removed the needle from the resident's skin;-LPN K did not hold the insulin pen under the skin for at least six seconds per the manufacturer's recommendation. 4. Record review of Resident #54's POS, dated May 2026, showed the following:-Insulin Lispro Junior KwikPen, inject as per sliding scale;-If blood sugar is 151-200, administer one unit of insulin;-If blood sugar is 201-250, administer three units of insulin;-If blood sugar is 251-300, administer five units of insulin;-If blood sugar is 301-400, administer seven units of insulin;-Administer insulin under the skin four times a day. Record review of Instructions for use of Humalog Junior KwikPen (insulin lispro), dated 3/31/20, showed the following:-Choose your injection site and insert the needle into the skin;-Continue to hold the dose knob in and slowly count to five before removing the needle. Observation on 5/20/26 at 7:20 A.M. showed the following:-LPN K primed the resident's insulin pen with 2 units of insulin;-LPN K prepped the resident's skin on his/her left upper arm with alcohol;-LPN K injected the needle in the resident's arm and pushed the dose knob to administer the 1 unit of ordered insulin;-LPN K immediately removed the needle from the resident's skin after he/she administered the insulin;-LPN K did not hold the needle under the resident's skin for a slow count of five before removing the needle per the manufacturer's recommendation. During an interview on 5/21/26 at 4:56 P.M., LPN K said the following:-LPN K did not know he/she should hold the needle under the skin for at least six seconds after he/she administered insulin from a pen;-He/She administered the ordered amount of insulin and then immediately removed the needle. That was how he/she was taught to do it. During an interview on 5/21/26 at 4:30 P.M., the Director of Nursing said she expected the staff to administer medication per physician orders and follow the manufacturer's guidelines for administering insulin pens. 5. Review of the facility policy, Indwelling Catheter Use and Removal, dated 10/01/25, showed the following:-Indwelling urinary catheters are catheters that remain in the bladder to assist with urinary elimination;-If an indwelling catheter is in use, the facility will provide appropriate care for the catheter in accordance with current professional standards of practice and resident care policies and procedures that include but are not limited to;-Additional care practices include securement of the catheter to facilitate flow of urine, prevention of kinks in the tubing and positioning below the level of the bladder. Review of Resident #7's Care Plan, dated 08/27/25, showed the following:-The resident had impaired cognitive function/dementia or impaired thought processes;-The resident had an ADL self-care performance deficit related to fracture (broken bone) of left ankle;-Dependent on staff and Hoyer lift (mechanical lift) for transfers;-The resident had an indwelling catheter related to urinary retention (inability to completely or partially empty the bladder). Review of the resident's Quarterly MDS, dated [DATE], showed the following:-Severe cognitive impairment;-Indwelling catheter;-Diagnoses of neurogenic bladder (the bladder does not empty properly due to a neurological condition) and dementia. Observation on 05/18/26 at 1:04 P.M. showed the following:-CNA G and the Restorative Aide (RA) prepared to transfer the resident from his/her wheelchair to the bed with the mechanical lift;-During the transfer, CNA G hung the resident's catheter drainage bag from the hooks on the mechanical lift, resulting in the drainage bag being higher than the resident's bladder. Dark yellow urine in the tubing flowed back towards the resident's bladder;-CNA G and the RA transferred the resident from the chair to his/her bed. During an interview on 05/21/26 at 11:35 A.M., CNA G said the catheter bag and tubing should always be kept below the (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	bladder. During an interview on 05/21/26 at 4:20 P.M. the DON said staff should always keep the urinary catheter bag and tubing below the level of the bladder.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure seven residents (Residents #7, #11, #24, #13, #60, #5 and #15), who required assistance with activities of daily living (ADLs), in a review of 23 sampled residents, received necessary care and services to maintain grooming and personal hygiene. The facility census was 71. Review of the facility policy, Grooming a Resident's Facial Hair, dated 10/01/25, showed it was the facility's practice to assist residents with grooming facial hair to help maintain proper hygiene as per current standards of practice. (The policy did not provide direction on how often staff were to shave a resident's facial hair.) Review of the facility policy, Resident Showers, dated 10/01/25, showed the following:-It was the facility's practice to assist residents with bathing to maintain proper hygiene, stimulate circulation and help prevent skin issues as per current standards of practice;-Staff will provide residents with showers as per request or as per facility schedule protocols and based upon resident safety;-Staff may give partial baths between regular shower schedules;-Assist the resident with showering as needed. Encourage the resident to participate as much as possible. Give help and verbal cues as needed. 1. Review of Resident #7's Care Plan, dated 08/27/25, showed the following:-The resident had impaired cognitive function/dementia or impaired thought processes;-The resident had an ADL self-care performance deficit;-Dependent on staff for bathing/showering. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 04/23/26, showed the following:-Severe cognitive impairment;-No rejection of care;-Dependent on staff for shower/bathing;-Required partial/moderate assistance for personal hygiene. Review of the resident's shower sheets, dated April 2026, showed the following:-On 04/02/26, staff gave the resident a shower and shaved the resident;-On 4/11/26, staff gave the resident a shower (nine days since his/her last documented shower). No documentation staff shaved the resident;-No documentation staff gave the resident a shower or shaved the resident from 04/12/26 through 04/30/26. Review of the resident's shower sheets, dated May 2026, showed the following:-On 05/06/26, staff gave the resident a shower and shaved the resident (25 days since his/her last documented shower)-On 05/07/26, staff gave the resident a shower and shaved the resident;-On 05/13/26, staff gave the resident a shower (six days since his/her last documented shower). No documentation staff shaved the resident;-No documentation staff gave the resident a shower or shaved the resident from 05/14/26 through 05/18/26. Observation on 05/18/26 at 11:12 A.M. showed the following:-The resident lay in bed;-His/Her face was covered with stubble, and his/her hair was greasy. Observation on 05/19/26 at 12:40 P.M. showed the following:-The resident sat in his/her wheelchair in the hallway;-His/Her face was covered with stubble that appeared longer than the day before, and his/her hair was greasy and disheveled. During an interview on 05/19/26 at 12:40 P.M., the resident said he/she had not had a shower in a week. He/She would like a shower. Observation on 05/20/26 at 5:01 A.M. showed the following:-The resident sat in his/her wheelchair in the dining room; -The resident's face was covered with stubble that appeared longer than the day before, and his/her hair was greasy. Observation on 05/21/26 at 9:05 A.M. showed the following:-The resident sat in his/her wheelchair in the hallway;-His/her face was covered with stubble that appeared longer than the day before, and his/her hair was greasy. 2. Review of Resident #11's shower sheets for the month of April 2026, showed the following: -On 04/01/26, staff gave the resident a shower and shaved the resident;-On 04/09/26, staff gave the resident a shower (eight days since his/her last documented shower);-On 04/15/26, staff gave the resident a shower and shaved the resident (six days since his/her last documented shower);-On 04/20/26, staff gave the resident a shower (five days since his/her last documented shower);-On 04/23/26, staff gave the resident a shower. Review of the resident's care plan, dated 05/08/26, showed the following:-Personal Care: staff will accommodate and support the resident's valued activities in care routine as able;-The resident preferred a shower (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	for bathing;-The resident had an activity for daily living (ADL) self-care performance deficit related to impaired mobility;-The resident required extensive assistance with showering and personal hygiene;-The resident required total assistance from two staff to transfer. Review of the resident's comprehensive MDS, dated [DATE], showed the following:-The resident did not reject any care;-The resident required substantial/maximum assistance from staff for bathing and personal hygiene (shaving). Review of the resident's shower sheets for May 2026 showed the following:-Staff did not document any showers for the resident from 05/01/26 through 05/17/26;-On 05/18/26, staff gave the resident a shower and shaved the resident (22 days since his/her last documented shower). During an interview on 5/18/26 at 10:18 A.M., the resident said the following:-Staff woke him/her at 4:00 A.M. to take a shower that day. It had been three weeks since his/her last shower;-He/She would really like to have two showers a week but there was only one person who usually gave showers at the facility;-He/She would like to be clean shaven and that didn't happen very often. 3. Review of Resident #24's care plan, dated 09/21/25, showed the following:-Anticipate and meet the resident's needs;-The resident had an ADL self-care performance deficit;-The resident required limited assistance from one staff for showering. Review of the resident's quarterly MDS, dated [DATE], showed the following:-The resident did not reject care;-The resident required partial to moderate assistance from staff for bathing;-The resident had impairment of both upper extremities. Review of the resident's shower sheets for the month of April 2026 showed the following: -On 04/01/26, staff gave the resident a shower; -On 04/07/26, staff gave the resident a shower (six days since his/her last documented shower); -On 04/15/26, staff gave the resident a shower (eight days since his/her last documented shower);-On 04/23/26, staff gave the resident a shower (eight days since his/her last documented shower). Review of the resident's shower sheets, dated 05/12/26, showed the following: -Staff did not document any showers for the resident from 05/01/26 through 05/11/26;-On 05/12/26, staff gave the resident a shower (19 days since his/her last documented shower). Observation on 05/18/26 at 9:26 A.M. showed the resident had hairs, approximately 0.25 to 0.5 inches long, on his/her chin. During an interview on 05/18/26 at 9:26 A.M., the resident said the following:-He/She got one shower a week if he/she was lucky; -He/She tried to keep himself/herself clean with wet wipes when he/she went to the bathroom. If he/she could keep his/her peri area clean, he/she felt that helped;-He/She did not like the chin hair and wished staff would pull them out. The staff never offered to shave his/her chin. 4. Review of Resident #13's admission MDS, dated [DATE], showed the following:-Cognitively intact;-No rejection of care;-Required substantial/maximal assistance for shower/bath;-Required supervision or touch assistance for personal hygiene. Review of the resident's Care Plan, dated 04/13/26, showed the following:-The resident had an ADL self-care performance deficit;-Bathing preference: shower;-The care plan did not include staff direction regarding the frequency of shaving or assistance required for personal hygiene. Review of the resident's shower sheets, dated April 2026, showed the following:-On 04/02/26, staff gave the resident a shower. No documentation staff shaved the resident;-On 04/09/26, staff gave the resident a shower (seven days since his/her last documented shower). No documentation staff shaved the resident;-On 04/16/26, staff gave the resident a shower (seven days since his/her last documented shower). No documentation staff shaved the resident;-On 04/21/26, staff gave the resident a shower (five days since his/her last documented shower). No documentation staff shaved the resident;-On 04/23/26, staff gave the resident a shower. No documentation staff shaved the resident. Review of the resident's shower sheets, dated May 2026, showed the following:-On 05/04/26, staff gave the resident a shower (11 days since his/her last documented shower). No documentation staff shaved the resident;-On 05/07/26, staff gave the resident shower. No documentation staff shaved the resident;-On 05/11/26, staff gave the resident shower. No documentation staff shaved the resident;-On 05/14/26, staff gave the resident shower. No documentation staff shaved the resident. Observation on 05/18/26 at 11:03 A.M. showed the following:-The resident sat in his/her wheelchair in his/her room;-His/Her chin was covered with hair, approximately 1 inch long. Observation on (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	05/19/26 at 3:42 P.M. showed the following:-The resident propelled himself/herself in a wheelchair down the hallway;-The resident's chin was covered with hair, approximately 1 inch long;-The resident had body odor. Observation on 05/20/26 at 10:00 A.M. showed the following:-The resident sat in his/her wheelchair in the dining room;-His/Her chin was covered with hair, approximately 1 inch long. Review of the resident's shower sheet, dated 05/21/26, showed staff gave the resident a shower and shaved the resident (seven days since his/her last documented shower). During interviews on 05/18/26 at 11:03 A.M. and 05/19/26 at 3:42 P.M., the resident said the following:-He/She was supposed to receive a shower twice a week;-Staff did not always give him/her two showers a week;-He/She was supposed to receive a shower on 05/18/26 but he/she did not receive a shower;-He/She hoped staff would give him/her a shower on 05/21/26 because he/she was going out with his/her family;-There was not enough staff to provide care for the residents and to give showers;-Staff only shaved him/her on shower days. 5. Review of Resident #60's shower sheets, dated April 2026, showed the following:-On 04/02/26, staff gave the resident a shower. No documentation staff shaved the resident-On 04/08/26 staff provided a shower (six days since his/her last documented shower). No documentation staff shaved the resident -On 04/13/26, staff documented the resident refused a shower three times;-On 04/20/26, staff gave the resident a shower (12 days since his/her last documented shower). No documentation staff shaved the resident-On 04/23/26, staff gave the resident a shower. No documentation staff shaved the resident;-On 04/27/26, staff gave the resident a shower and shaved the resident. Review of the resident's Care Plan, dated 04/27/26, showed the following:-Bathing preference: shower;-The resident has an ADL self-care performance deficit;-No direction regarding frequency of shaving or assistance required for personal hygiene. Review of the resident's quarterly MDS, dated [DATE], showed the following:-Severe cognitive impairment;-No rejection of care;-Required substantial/maximal assistance for shower/bathing;-Required partial/moderate assistance for personal hygiene. Review of the resident's shower sheets, dated May 2026, showed the following:-On 05/04/26, staff gave the resident a shower (seven days since his/her last documented shower). No documentation staff shaved the resident;-On 05/15/26, staff gave the resident a shower and shaved the resident (11 days since his/her last documented shower). Observation on 05/18/26 at 11:12 A.M. showed the following:-The resident sat in his/her wheelchair in his/her room watching TV;-The resident's face was covered with stubble;-The resident had white flaky skin on his/her shirt. Observation on 05/19/26 at 1:12 P.M. showed the following:-The resident sat in his/her wheelchair in his/her room watching TV;-The resident's face was covered with stubble that appeared longer than the day before.-The resident had white flaky skin on his/her shirt. Observation on 05/21/26 at 9:08 A.M. showed the following:-The resident sat in his/her wheelchair in his/her room watching TV;-The resident's face was covered with stubble that appeared longer than the previous three days;-The resident had white flaky skin on his/her shirt. During an interview on 05/21/26 at 9:08 A.M., the resident said he/she would like to be shaved because he/she liked to be clean shaven. 6. Review of Resident #5's quarterly MDS, dated [DATE], showed the following:-His/Her cognition was severely impaired;-He/She was frequently incontinent of bladder;-He/She was always incontinent of bowel;-He/She required partial/moderate assistance with personal hygiene;-He/She required substantial/maximum assistance with shower/bathing and transfer to and from shower/bath. Review of the resident's care plan, last updated on 04/07/26, showed the following:-He/She was incontinent of bowel and bladder and required assistance of one staff with toileting and hygiene;-He/She showered twice a week, shampoo weekly, trim toenails and fingernails weekly and as needed;-Assist the resident with shaving as needed;-He/She was usually noncompliant with bathing and hygiene. Review of the resident's shower sheets, dated 05/01/26 through 05/20/26, showed the following:-On 5/1/26, staff gave the resident a shower;-On 5/15/26, staff gave the resident a shower (14 days since his/her last documented shower);-No documentation the resident refused any offered showers. Observation on 05/20/26 at 6:00 A.M. showed the resident had a foul body odor and untrimmed (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	fingernails. 7. Review of Resident #15's care plan, last revised on 02/09/26, showed he/she was incontinent of bowel and bladder and needed staff to check him/her for incontinence and provide peri care as needed. Review of the resident's significant change in status MDS, dated [DATE], showed the following:-His/Her cognition was severely impaired;-He/She was dependent on staff for bathing and toilet hygiene;-He/She was always incontinent of bowel and bladder. Review of the residents' shower sheets from 04/01/26 to 04/30/26 showed the following:-No documentation staff gave the resident a shower from 04/01/26 through 04/16/26;-On 04/17/26, 04/21/26, 04/24/26, and 04/28/26 staff gave the resident a shower;-There was no documentation the resident refused showers. Observation on 05/20/26 at 9:11 A.M. showed the following:-CNA G and CNA H assisted the resident to the bed and removed his/her pants;-The resident was incontinent of foul smelling urine and his/her perineal area was reddened;-CNA G cleaned urine from the resident's perineal area with a wipe. The resident continued to urinate, CNA G cleansed more urine from the perineal area with a wipe, but did not allow the resident to finish urinating before placing a clean incontinence brief under the resident and securing it in place. During an interview on 05/20/26 at 9:20 A.M., CNA G said he/she should have ensured the resident was finished urinating before he/she applied a new incontinence brief on the resident. He/She did not have enough time to do it properly because they did not have enough staff and he/she was rushed to care for the other residents. 8. During an interview on 05/18/26 at 9:50 A.M., CNA E said usually, there was only one CNA on the special care unit (where the resident lived). He/She could not give the residents their showers. The special care unit was not equipped with a shower room, so staff had to leave the unit with a resident to give a shower. It was not possible to leave the unit to give the residents a shower when there was only one staff on the unit. During an interview on 05/19/26 at 1:20 P.M., CNA A said the residents rarely received two showers a week because there were not enough staff to complete them. During an interview on 5/20/26 at 12:56 P.M. CNA E said the following:-He/She got pulled from being the scheduled shower aide; -Staff filled out and turned in a shower sheet when staff gave a shower or when staff offered a shower and the resident refused. During an interview on 05/21/26 at 9:05 A.M., CNA B said staff only shaved the residents on their shower days. During an interview on 05/21/26 at 11:35 A.M., CNA G said the following:-CNA staff were responsible for shaving residents, but they did not have time because the facility did not have enough staff;-Staff only shaved residents if they got a shower. During an interview on 5/21/26 at 1:26 P.M. CNA C said the following:-CNA E got pulled from being the scheduled shower aide to work on the floor often;-He/She could not give showers to all the residents scheduled on Monday and Tuesday if he/she was the only shower aide;-He/She arrived at the facility at 4:00 A.M. today to start on showers so he/she could get them completed;-He/She went in early almost every day in order to give residents their showers. During an interview on 05/21/26 at 4:30 P.M., the Director of Nursing (DON) said she was unaware the shower aide was being pulled to the floor and residents were not receiving their showers.

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide sufficient staff to meet residents' needs for seven residents (Resident #6, #71, #7, #11, #24, #15 and #5), in a review of 23 sampled residents, and for one additional resident (Resident #43). Staff failed to provide restorative therapy when the restorative aide (RA) was pulled to work as a certified nurse assistant (CNA) and was unable to complete duties for the restorative therapy nursing program. The facility failed to ensure sufficient staff were available to provide routine showers to ensure good personal hygiene and failed to ensure there was sufficient staff to provide assistance with residents' activities of daily living and care needs. The facility census was 71. Review of the Facility Assessment, last revised on 09/23/25, showed the following:-Staffing decisions are determined at the facility level (corporate input may be included) to ensure there are enough staff with appropriate competencies and skill sets necessary to care for its residents' needs as identified through resident assessments and plans of care.;-The facility will consider staffing needs for each shift, such as day, evening and night, and will adjust as necessary based on any changes to its resident population;-The facility will develop and maintain a plan to maximize recruitment and retention of direct care staff;-The facility will have contingency planning for events that do not require activation of the facility's emergency plan, but do have the potential to affect resident care, such as, but not limited to, the availability of direct care nurse staffing or other resources as needed for resident care; -Assessment process includes evaluating the overall staffing requirements to ensure we have an adequate number of qualified personnel available to meet each resident's specific needs as outlined in their assessments and care plans. This approach ensures that our staffing aligns closely with resident care requirements;-Services provided included activities of daily living (bathing, showers, oral/denture care, dressing, eating, support with needs related to hearing/vision/sensory impairment, restorative nursing, contracture prevention/care; bowel/bladder toileting programs, incontinence prevention and care, and building of relationships with the resident to get to know him/her, then engage resident/representatives in conversation to find out what resident's preferences and routines are, what makes a good day for the resident, and what upsets him/her;-The facility systematically evaluates the staffing requirements to ensure sufficient qualified personnel are available to meet each resident's individual needs;-Direct Care staff for the secured unit (SCU) included a CNA for eight to 16 hours for both days and evenings. (There was no documentation in the facility assessment of night staff utilized on the SCU.) Review of the facility policy, Nursing Services and Sufficient Staff, dated 10/1/25, showed the following:-It is the policy of this facility to provide sufficient staff with appropriate competencies and skill sets to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care;-The facility will supply services in sufficient numbers on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans;-The facility is required to provide licensed nursing staff 24 hours a day along with other nursing personnel, including but not limited to nurse aides;-Providing care includes, but is not limited to, assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. 1. Review of Resident #71's physician order sheet (POS), dated 5/21/26, showed the following:-On 4/28/26, staff received an order for the resident to begin restorative therapy;-Active range of motion, passive range of motion, transfers and bilateral upper and lower strengthening. Review of the resident's restorative therapy log from 5/1/26 to 5/21/26 showed the following:-Staff provided the resident with restorative therapy on 5/1/26 and 5/13/26;-The Restorative Aide was pulled to the floor to work as a CNA on 5/4/26, 5/5/26, 5/12/26, 5/14/26, 5/18/26, 5/19/26, and 5/20/26. During an interview on 5/18/26 at 10:10 A.M. Resident #71 said the following:-He/She was supposed to get (continued on next page)

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	265407	A. Building B. Wing	05/21/2026

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	restorative therapy, but it didn't always happen;-The resident thought he/she was scheduled for more therapy than he/she received. 2. Review of Resident #6's Physician's Orders, dated April 2026, showed an order for restorative therapy as follows: PROM contracture prevention program seated or supine strength. Review of the resident's Restorative Therapy Log, dated April 2026, showed the following:-The resident received restorative therapy 04/01/26, 04/02/26, 04/08/26, 04/13/26, 04/15/26, 04/16/26, 04/17/26, 04/20/26, 04/22/26, 04/24/26 and 04/30/26;-The RA documented he/she was pulled to work on the floor as a CNA on 04/10/26, 04/21/26, 04/23/26, 04/27/26 and 04/28/26. Review of the resident's Physician's Orders, dated May 2026, showed an order for restorative therapy as follows: PROM contracture prevention program seated or supine strength. Review of the resident's Restorative Therapy Log, dated 05/01/26 through 05/17/26, showed the following:-The resident received restorative therapy 05/01/26 and 05/13/26;-The resident refused restorative therapy on 05/06/26;-The RA was pulled to the floor on 05/04/26, 05/05/26, 05/12/26 and 05/15/26. Observation on 05/19/26 at 8:20 A.M. showed the following:-The resident sat in a reclining wheelchair in the dining room;-Both of his/her hands were contracted;-He/She had foot drop (inability to lift the front part of the foot) in both of his/her feet;-The RA worked as a CNA passing trays and assisting residents with dining. During an interview on 05/19/26 at 8:20 A.M., the resident said the following:-He/She could not hold drinks or utensils with his/her hands;-He/She was supposed to receive restorative therapy when the RA had time and wasn't working as a CNA;-He/She tried to exercise his/her own hands when the RA was working as a CNA, but he/she was unable to do exercises independently with his/her legs;-The range of motion exercises helped with his/her flexibility. 3. Review of Resident #43's Physician's Orders, dated April 2026, showed an order for the resident to participate in restorative nursing program for 24 weeks/180 days per therapy/primary care physician (PCP) recommendations. Review of the resident's Restorative Therapy Log, dated April 2026, showed the following:-The resident received restorative therapy 04/01/26, 04/02/26, 04/08/26, 04/13/26, 04/15/26, 04/17/26, 04/20/26, 04/22/26, and 04/24/26;-The RA documented he/she was pulled to the floor to work as a CNA on 04/10/26, 04/21/26, 04/23/26, and 04/27/26. Review of the resident's Physician's Orders, dated April 2026, showed a new order for restorative therapy as follows: lower extremity stretched all directions emphasis on knee extension to reduce contraction (start date 04/28/26). Review of the resident's Restorative Therapy Log dated April 2026 showed the following:-The RA documented he/she was pulled to the floor to work as a CNA on 04/28/26;-The resident received restorative therapy on 04/30/26. Review of the resident's Physician's Orders, dated May 2026, showed an order for restorative therapy as follows: lower extremity stretched all directions emphasis on knee extension to reduce contraction. Review of the resident's Restorative Therapy Log, dated 05/01/26-05/21/26, showed the following:-The RA documented he/she was pulled to the floor to work as a CNA on 05/04/26, 05/05/26, 05/12/26, 05/14/26, 05/18/26 and 05/19/26;-The resident received restorative therapy on 05/01/26, 05/20/26 and 05/21/26. 4. Review of Resident #7's shower sheets, dated April 2026, showed the following:-On 04/02/26, staff gave the resident a shower and shaved the resident;-On 4/11/26, staff gave the resident a shower (nine days since his/her last documented shower). No documentation staff shaved the resident;-No documentation staff gave the resident a shower or shaved the resident from 04/12/26 through 04/30/26. Review of the resident's shower sheets, dated May 2026, showed the following:-On 05/06/26, staff gave the resident a shower and shaved the resident (25 days since his/her last documented shower)-On 05/07/26, staff gave the resident a shower and shaved the resident;-On 05/13/26, staff gave the resident a shower (six days since his/her last documented shower). No documentation staff shaved the resident;-No documentation staff gave the resident a shower or shaved the resident from 05/14/26 through 05/18/26. Observation on 05/18/26 at 11:12 A.M. showed the following:-The resident lay in bed;-His/Her face was covered with stubble, and his/her hair was greasy. Observation on 05/19/26 at 12:40 P.M. showed the following:-The resident sat in his/her wheelchair in the hallway;-His/Her face was covered with stubble that appeared longer (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	than the day before, and his/her hair was greasy and disheveled. During an interview on 05/19/26 at 12:40 P.M., the resident said he/she had not had a shower in a week. He/She would like a shower. Observation on 05/20/26 at 5:01 A.M. showed the following:-The resident sat in his/her wheelchair in the dining room; -The resident's face was covered with stubble that appeared longer than the day before, and his/her hair was greasy. Observation on 05/21/26 at 9:05 A.M. showed the following:-The resident sat in his/her wheelchair in the hallway;-His/her face was covered with stubble that appeared longer than the day before, and his/her hair was greasy. 5. Review of Resident #11's shower sheets for the month of April 2026, showed the following: -On 04/01/26, staff gave the resident a shower and shaved the resident;-On 04/09/26, staff gave the resident a shower (eight days since his/her last documented shower);-On 04/15/26, staff gave the resident a shower and shaved the resident (six days since his/her last documented shower);-On 04/20/26, staff gave the resident a shower (five days since his/her last documented shower);-On 04/23/26, staff gave the resident a shower. Review of the resident's care plan, dated 05/08/26, showed the following:-The resident preferred a shower for bathing;-The resident required extensive assistance with showering and personal hygiene. Review of the resident's comprehensive Minimum Data Set (MDS), a federally mandated assessment instrument, dated 5/13/26, showed the following:-The resident did not reject any care;-The resident required substantial/maximum assistance from staff for bathing and personal hygiene (shaving). Review of the resident's shower sheets for May 2026 showed the following:-Staff did not document any showers for the resident from 05/01/26 through 05/17/26;-On 05/18/26, staff gave the resident a shower and shaved the resident (22 days since his/her last documented shower). During an interview on 5/18/26 at 10:18 A.M., the resident said the following:-Staff woke him/her at 4:00 A.M. to take a shower that day. It had been three weeks since his/her last shower;-He/She would really like to have two showers a week but there was only one person who usually gave showers at the facility;-He/She would like to be clean shaven and that didn't happen very often. 6. Review of Resident #24's care plan, dated 09/21/25, showed the resident required limited assistance from one staff for showering. Review of the resident's quarterly MDS, dated [DATE], showed the following:-The resident required partial to moderate assistance from staff for bathing;-The resident had impairment of both upper extremities. Review of the resident's shower sheets for the month of April 2026 showed the following: -On 04/01/26, staff gave the resident a shower; -On 04/07/26, staff gave the resident a shower (six days since his/her last documented shower); -On 04/15/26, staff gave the resident a shower (eight days since his/her last documented shower);-On 04/23/26, staff gave the resident a shower (eight days since his/her last documented shower). Review of the resident's shower sheets, dated 05/12/26, showed the following: -Staff did not document any showers for the resident from 05/01/26 through 05/11/26;-On 05/12/26, staff gave the resident a shower (19 days since his/her last documented shower). Observation on 05/18/26 at 9:26 A.M. showed the resident had hairs, approximately 0.25 to 0.5 inches long, on his/her chin. During an interview on 05/18/26 at 9:26 A.M., the resident said the following:-He/She got one shower a week if he/she was lucky; -He/She tried to keep himself/herself clean with wet wipes when he/she went to the bathroom. If he/she could keep his/her peri area clean, he/she felt that helped;-He/She did not like the chin hair and wished staff would pull them out. The staff never offered to shave his/her chin. 7. Review of Resident #15's significant change in status MDS, dated [DATE], showed he/she was dependent on staff for bathing. Review of the resident's shower sheets from 04/01/26 to 04/30/26 showed the following:-No documentation staff gave the resident a shower from 04/01/26 through 04/16/26;-On 04/17/26, 04/21/26, 04/24/26, and 04/28/26 staff gave the resident a shower;-There was no documentation the resident refused showers. Observation on 05/20/26 at 9:11 A.M. showed the following:-Certified Nurse Assistant (CNA) G and CNA H assisted the resident to the bed and removed his/her pants;-The resident was incontinent of foul smelling urine and his/her perineal area was reddened;-CNA G cleaned urine from the resident's perineal area with a wipe. The resident continued to urinate, CNA G cleansed more urine from the perineal area with a wipe, but did not allow (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the resident to finish urinating before placing a clean incontinence brief under the resident and securing it in place. During an interview on 05/20/26 at 9:20 A.M., CNA G said he/she should have ensured the resident was finished urinating before he/she applied a new incontinence brief on the resident. He/She did not have enough time to do it properly because they did not have enough staff and he/she was rushed to care for the other residents. 8. Review of Resident #5's quarterly MDS, dated [DATE], showed he/she required substantial/maximum assistance with shower/bathing. Review of the resident's care plan, last updated on 04/07/26, showed the following:-He/She showered twice a week, shampoo weekly, trim toenails and fingernails weekly and as needed;-Assist the resident with shaving as needed. Review of the resident's shower sheets, dated 05/01/26 through 05/20/26, showed the following:-On 5/1/26, staff gave the resident a shower;-On 5/15/26, staff gave the resident a shower (14 days since his/her last documented shower);-No documentation the resident refused any offered showers. Observation on 05/20/26 at 6:00 A.M. showed the resident had a foul body odor and untrimmed fingernails. 9. During interviews on 05/20/26 at 6:00 A.M. and 05/21/26 at 11:58 A.M., the Restorative Aide said the following:-He/She was often pulled from restorative duties to assist with resident care which made it difficult to complete restorative therapy three times a week;-He/She was pulled from his/her restorative duties to work on the floor often;-He/She could not complete restorative therapy sessions with residents when he/she was working on the floor. During an interview on 5/21/26 at 2:00 P.M., the Director of Rehabilitation said he added orders in a range of three to six times a week for each resident. He did this because the Restorative Aide was pulled from his/her duties to work on the floor. 10. During an interview on 05/21/26 at 11:35 A.M., CNA G said CNA staff were responsible for shaving residents, but they did not have time because the facility did not have enough staff. During an interview on 5/21/26 at 1:26 P.M., CNA C said the following:-The other shower aide was pulled from being the scheduled shower aide to work on the floor often;-He/She could not complete showers for all residents scheduled on Monday and Tuesday if he/she was the only shower aide. During an interview on 05/19/26 at 1:20 P.M., CNA A said the residents rarely received two showers a week because there were not enough staff to complete them. During an interview on 05/18/26 at 9:50 A.M., CNA E said he/she worked the previous weekend (05/15/26 and 05/17/26) on the special care unit (SCU). He/She was the only staff on the unit. On Sunday (05/17/26), he/she provided care for residents on E hall and F hall and the SCU from 6:00 A.M. until 9:30 A.M. There was usually one staff scheduled on the SCU with residents who required assistance from two staff to transfer. Residents had to wait until a second staff member could assist him/her with the transfer. Staff on the SCU were responsible for giving the residents on the SCU their showers. The special care unit was not equipped with a shower room, so staff had to leave the unit with a resident to give a shower. It was not possible to leave the unit to give the residents a shower when there was only one staff on the unit. During an interview on 05/19/26 at 8:20 A.M., CNA D said there was usually one CNA on the SCU. He/She could not give the residents their showers when there was only one CNA. There wasn't a shower located on the SCU, and staff had to take the residents off the SCU to use the shower. During an interview on 05/19/26 at 2:05 P.M., CNA Z said he/she was the only CNA on the SCU today and was not sure if there was someone to come assist him/her. This was his/her first time working at the facility and he/she really didn't know much about the residents. During an interview on 05/19/26 at 4:25 P.M., CMT J said there were supposed to be two staff members on the SCU at all times, but half the time, there was only one staff member. During an interview on 05/21/26 at 2:45 P.M., Licensed Practical Nurse (LPN) T said typical daily staffing consisted of one charge nurse, one CNA for halls E and F, one CNA for the SCU (C hall), and two CNAs for halls A and B. It was difficult for one charge nurse to oversee all the residents. During an interview on 05/21/26 at 4:30 P.M., the Director of Nursing (DON) said she was not aware the shower aide was pulled to the floor and residents were not receiving their showers. Restorative therapy should be completed as ordered. She was aware the Restorative Aide was to the floor because there was not enough staff.