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	09/18/2024

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 0558 Level of Harm - Actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42592 Based on observation, interview, and record review, the facility failed to provide reasonable accommodation of needs for one resident (Resident #4), in a review of 24 sampled residents, when staff did not ensure the resident had a comfortable wheelchair that fit him/her properly and did not cause him/her discomfort and pain. The resident presented with an increase in depression symptoms and reported that due to not having a comfortable wheelchair, he/she stayed in bed and felt abandoned, thrown away and like nobody cared. The facility also failed to ensure call lights were within reach for three residents (Residents #3, #22 and #29), in a review of 24 sampled residents. The facility census was 64. Review of the facility policy, Accommodation of Needs, revised 03/2021, showed the following: -Our facility's environment and staff behaviors are directed toward assisting the resident in maintaining and/or achieving safe independent functioning, dignity and well-being; -1. The resident's individual needs and preferences are accommodated to the extent possible, except when the health and safety of the individual or other residents would be endangered; -2. The resident's individual needs and preferences, including the need for adaptive devices and modifications to the physical environment, are evaluated upon admission and reviewed on an ongoing basis; -4. In order to accommodate individual needs and preferences, staff attitudes and behaviors are directed towards assisting the residents in maintaining independence, dignity and well-being to the extent possible and in accordance with the residents' wishes. For example: a. interacting with the residents in ways that accommodate the physical or sensory limitations of the residents, promote communication, and maintain dignity. Review of the facility policy, Resident Call System, dated 01/30/24, showed the following: -Ensure that residents have a means of direct communication between the resident and his/her caregivers when in their rooms and toilet and bathing areas; -The call system must be accessible to residents while in their bed or other sleeping accommodations within the resident's room. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0558 Level of Harm - Actual harm Residents Affected - Few	1. Review of Resident #4's undated Continuity of Care Document (CCD) showed the following: -Admission to the facility on [DATE]; -Diagnoses included acquired absence of right leg above knee, osteoarthritis of right and left shoulder, anxiety disorder, depression, and legal blindness; -Goals: He/She will be allowed to safely smoke cigarettes, with supervision. He/She will participate in activities of choice at least two times weekly through next review. He/She will be comfortable and free from signs and symptoms of pain through next review. His/Her care plan will be followed through next review. Review of the resident's annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 05/03/24, showed the following: -Cognitively intact; -Able to make self-understood and understood others; -Moderately impaired vision - can identify objects; -Feeling down, depressed or hopeless; -Mild depression; -Activities that were very important to the resident included attending favorite activities and going outside when the weather was good; -Scheduled pain medication with complaints of frequent, moderate pain; -Pressure reducing device for chair; -Current tobacco user. Review of the resident's Telehealth Notes, dated 7/17/24, showed the following: -The resident was seen for follow-up related to psychotropic medication management and mood; -The resident had stopped going out for meals and smoking (no indication as to why); -The resident reported his/her mood was fair; -Feeling down, depressed or hopeless: several days; -Mood: discouraged; -Nonpharmacological recommendations: encourage the resident to continue to engage in meaningful activities. (continued on next page)

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F 0558 Level of Harm - Actual harm Residents Affected - Few	Review of the resident's quarterly MDS, dated [DATE], showed the following: -Cognitively intact; -Able to make self-understood and understood others; -Moderately impaired vision - can identify objects; -Feeling down, depressed or hopeless; -Mild depression; -No behaviors or rejection of cares; -Required substantial/maximum assistance with upper body dressing, personal hygiene, and rolling from left to right; -Dependent on staff for lower body dressing, putting on/taking off footwear, sitting to lying transfer, lying to sitting on the side of the bed, chair/bed-to-chair transfers, tub/shower transfers and all aspects of wheelchair mobility; -Scheduled pain medication with complaints of frequent, moderate pain; -Pressure reducing device for bed and chair; -No indication on MDS of tobacco use status. Review of the resident's Telehealth notes, dated 08/07/24, showed the following: -The resident was seen for follow up on mood and behaviors; -The resident reported his/her mood had been the same and continues to feel down on a daily basis; -Feeling down, depressed or hopeless: several days; -Nonpharmacological recommendations: encourage the resident to continue to engage in meaningful activities. Review of the resident's Telehealth notes, dated 08/12/24, showed the following: -The resident has poor eyesight, so he/she spent much of his/her day listening to books on tape; -Feeling down, depressed or hopeless: more than half of the days; -The resident was referred by the facility for psychotherapy due to possible increase in depressive and anxiety symptoms; -The resident reported he/she had been doing ok; (continued on next page)

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F 0558 Level of Harm - Actual harm Residents Affected - Few	-Mood: within normal limits, depressed/sad; -Interventions: supportive active listening ad rapport building, encouraged the resident to participate in social activities and continue to encourage contact with family, friends and staff; -Recommendations: encourage adherence to daily schedules and provide opportunities during the day for cognitive and mental stimulation. Review of the resident's September 2024 Physician Order Sheets showed the following: -May participate in activities as tolerated; -Pressure reducing device (wheelchair cushion) utilized in wheelchair every shift (original order dated 03/20/24); -High back reclining wheelchair for positioning, support and comfort (original order dated 03/27/24). Observation on 09/16/24 at 4:02 P.M. showed the following: -The resident lay in bed with his/her eyes closed. He/She had head phones on his/her ears connected to a book on tape; -A high back wheelchair sat at the resident's bedside. A positioning cushion was on the left arm rest of the wheelchair. There was no pressure relieving cushion present in the seat of the wheelchair. During interviews on 09/16/24 at 4:02 P.M., 4:25 P.M. and 5:03 P.M., the resident said the following: -He/She did not get up anymore because his/her wheelchair hurt him/her so bad that he/she did not get up; -The wheelchair hurt his/her back, hips and shoulders; -He/She had bad shoulders and the wheelchair squeezed his/her hips; -The pain in his/her hips transferred to his/her buttocks and caused pressure; -The wheelchair had caused discomfort for quite some time; he/she was unsure exactly how long but as long as he/she had the chair (original order for the chair was 3/27/24); -He/She told anyone and everyone that would listen that his/her wheelchair hurt when he/she was in it, but nothing was done about it. He/She still had the chair that hurt. Sometimes he/she went to physician appointments in the wheelchair and that hurt his/her body; -He/She ate meals in his/her room, but would like to go to the dining room if he/she had a wheelchair that was comfortable; (continued on next page)

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F 0558 Level of Harm - Actual harm Residents Affected - Few	-He/She would like to get out of his/her room and listen to conversations. It would be a nice change of scenery. If he/she was stuck in bed, he/she could not make friends; -He/She would like to get up out of bed to smoke, but he/she could not get up to smoke because of how uncomfortable his/her wheelchair made him/her; -He/She would like to smoke at least two times a day. He/She usually only got up to smoke once. One day last week, he/she was hurting so bad because of the wheelchair that he/she only smoked once and went inside to supper. He/She was hurting so bad that he/she could not eat. He/She had to sit in the chair for a couple of hours and it was horrible; -He/She did not know for sure when he/she smoked last, maybe two or three days ago, that was the time he/she sat up and was hurting so bad and did not eat; -If he/she had a more comfortable chair, he/she would smoke more than once a day and get up for meals and possibly more activities; -Since he/she was stuck in bed because the wheelchair caused discomfort and pain, he/she felt abandoned, like he/she had been thrown away and like nobody cared about him/her. Observation on 09/17/24 at 5:30 A.M., showed the resident lay in bed asleep with the same high back wheelchair at his/her bedside. No pressure relieving cushion was present in the seat of the wheelchair or visible in the surrounding area of the room. Review of the resident's Care Plan, revised 09/17/24, showed the following: -He/She had frequent complaints of chronic bilateral shoulder pain, neck and chronic back pain due to osteoarthritis; -He/She would be comfortable and free from signs and symptoms of pain through the next review; -Assist him/her to a position of comfort and reposition as needed; -He/She was at risk for skin breakdown due to limited mobility and had a pressure reducing cushion in his/her wheelchair; -He/She was on medications for depression and anxiety. Monitor him/her for any sign or symptoms of depression, and if any are noted, report to the charge nurse; -He/She would benefit from interactions with others during group activities; -He/She will participate in activities of choice at least two times weekly through next review; -He/She enjoyed audio books, manicures, listening to classical music, and going outdoors to smoke; -He/She was a smoker and would like to continue to smoke during his/her stay at the facility; (continued on next page)

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F 0558 Level of Harm - Actual harm Residents Affected - Few	-He/She smoked cigarettes daily. Staff will provide the resident with his/her cigarettes when it is smoke time. During an interview on 09/17/24, at 6:34 A.M., Certified Nursing Assistant (CNA) G said the following: -The resident was a smoker; -The resident told staff when they got him/her up if he/she wanted to smoke, which was usually only one time a day; -The resident had complained that his/her wheelchair caused him/her discomfort or pain when he/she got up and that was why the resident did not like to get up much; -The resident did not participate in activities and wanted to stay in bed because the wheelchair hurt him/her when he/she got up. During an interview on 09/17/24, at 8:10 A.M., CNA C said the following: -The resident was a smoker but did not smoke very often, usually just at the 2:00 P.M. smoke break; -The resident told staff when he/she wanted to smoke; -He/She had never specifically asked the resident why he/she did not want to get out of bed more; -The resident complained that his/her wheelchair caused discomfort and pain when he/she was up in the chair; -He/She was aware the resident wanted a more comfortable wheelchair. During an interview on 09/17/24, at 8:23 A.M., CNA D said the following: -The resident was a smoker but only liked to be up for the afternoon smoke time; -The resident did not want to get up to smoke because he/she hurt when up in his/her wheelchair; -The resident voiced complaints about his/her wheelchair causing discomfort or pain; -The resident's hips were too tight in the current chair; -The resident did not participate in activities and did not come out of his/her room because his/her wheelchair caused him/her discomfort; -The resident only got up for one meal, dinner, when he/she got up because the wheelchair caused discomfort; -He/She was aware the resident wanted a more comfortable wheelchair; (continued on next page)

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F 0558 Level of Harm - Actual harm Residents Affected - Few	-The resident told him/her that he/she felt alone and that no one cared. He/She reported this to the charge nurse when it occurred, but he/she was unsure who he/she reported it to and when. During interviews on 09/27/24 at 11:43 A.M., and 10/2/24 at 8:32 A.M., the Activities Director said the following: -The resident did not like to get out of bed because he/she did not like to sit in his/her wheelchair because his/her body hurt; -The resident told her (unsure when this occurred) one time that he/she did not attend group activities and did not get out of bed, because he/she was in pain and his/her wheelchair caused discomfort; -The last time the resident was in a group activity (prior to the recertification survey), the resident complained that his/her neck and back were hurting; -She did not report the wheelchair caused discomfort to anyone. During an interview on 09/17/24, at 9:03 A.M., the Director of Nursing (DON) said the following: -The resident only smoked one time a day; -The staff took the resident to smoke when he/she requested; -Sometimes the resident got up and sometimes he/she did not; -The resident did not participate in activities and chose to stay in his/her room and listen to books on tape; -The resident usually just got up for one meal, usually lunch; -She did not specifically ask the resident why he/she did not want to get out of bed more; -She was not aware the resident had not been out of bed since Friday due to complaints about the wheelchair causing him/her discomfort or pain; -She was not aware the resident would like to smoke more, wanted to attend more activities, or felt alone/thrown away or like no one cares about him/her. During an interview on 09/17/24 at 9:14 A.M., and 09/25/24 at 3:45 P.M., the Administrator said the following: -The resident very rarely requested to smoke, mainly only when he/she was out of bed; -The resident did not usually attend group activities, just usually one-on-one activities with the activities director; -To her knowledge, the resident never expressed the desire to attend group activities; (continued on next page)

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F 0558 Level of Harm - Actual harm Residents Affected - Few	-The resident got up sometimes for one meal a day by his/her choice; -She was not aware the resident would like to go out and smoke more or wanted to attend more activities; -She was aware the resident made statements of feeling alone and triggered for depression; the resident received counseling services for his/her depression; -Prior to 09/17/24, she was unsure if anyone specifically asked the resident why he/she was not getting out of bed. The resident usually requested when he/she wanted to get up and typically only got up one time per day. 2. Review of Resident #22's Face Sheet showed the resident's diagnoses included dementia with behaviors, Parkinson's disease (a disorder that affects movement symptoms are slow movement, stiffness, and loss of balance), anxiety, depression, a history of a stroke, and an unspecified mood disorder. Review of the resident's annual MDS, dated [DATE], showed the following: -Severe cognitive impairment; -Was usually understood and usually understood others; -Moderately impaired vision with corrective lenses; -Dependent on staff for transfers. Review of the resident's Care Plan, last reviewed on 06/18/2024, showed the following: -At high risk for falls; -The resident was forgetful and confused with very poor vision, weak and unsteady. -Required the assistance of one to two staff with transfer and ADLs; -History of falls; -Ensure the resident's call light is within reach at all times. Observation on 09/16/24, at 4:47 P.M., showed the resident in his/her room in a recliner. The resident's feet are elevated high in the chair. The resident's call light was across the room and clipped high up on the curtain that divided the room. The call light was not in the resident's reach. During an interview on 09/16/24, at 4:47 P.M., the resident said he/she used his/her call light to call for help if he/she could find it. The resident asked, do you know where it is? The resident said he/she could not put the feet down on his/her recliner. (continued on next page)

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F 0558 Level of Harm - Actual harm Residents Affected - Few	Observation on 09/17/24, at 4:08 P.M., showed the resident sat reclined in the recliner chair in his/her room. The resident has his/her eyes open. The resident's call light was across the room and clipped high up on the curtain that divided the room. The call light was not in the resident's reach. 3. Review of Resident #3's Face Sheet showed the resident's diagnoses included Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), vascular dementia (brain damage caused by multiple strokes, major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life) and anxiety disorder (a mental health disorder characterized by feelings of worry or fear that are strong enough to interfere with one's daily activities). Review of the resident's quarterly MDS, dated [DATE], showed the following: -Severely impaired cognition; -Clear speech, usually made self understood and usually understood others; -Required partial/moderate staff assistance for rolling left and right; -Required substantial/maximum staff assistance for sitting to lying, lying to sitting on side of bed, and wheelchair mobility; -Dependent on staff for chair/bed-to-chair transfers. Review of the resident's Care Plan, reviewed on 7/11/24, showed the following: -He/She was forgetful, confused, and unsteady with poor safety awareness, poor wheelchair positioning and a history of falls; -He/She needed assist of one to two with all activity of daily living (ADL) care; -Make sure his/her call light is within reach at all times. Observation on 09/17/24, at 5:30 A.M., showed the resident lay in bed sleeping. The resident's call light was draped over the end of the foot board out of the resident's reach. Observation on 09/18/24, at 8:30 A.M., showed the resident sat in his/her wheelchair watching television. The resident's call light was across the room on the bed out of the resident's reach. 4. Review of Resident #29's Face Sheet showed the resident's diagnoses included dementia (a group of thinking and social symptoms that interferes with daily functioning) and anxiety disorder. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Severely impaired cognition; -Adequate hearing, clear speech, sometimes understood others; (continued on next page)

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F 0558 Level of Harm - Actual harm Residents Affected - Few	-Dependent on staff assistance for rolling left and right, sit to lying, lying to sitting on side of bed, chair/bed-to-chair transfers, wheelchair mobility. Review of the resident's Care Plan, reviewed on 07/18/24, showed the following: -He/She was weak and unsteady and at risk for falls; -He/She needed assistance with all ADL care; -Make sure his/her call light is within reach at all times. Observation on 09/17/24, at 5:32 A.M., showed the resident lay in bed sleeping. The resident's call light was across the room in the recliner out of the resident's reach. Observation on 09/18/24, at 8:35 A.M., showed the resident sat in the middle of the room in his/her Broda chair. The resident's call light sat in the recliner out of the resident's reach. 5. During an interview on 09/28/24, at 11:34 A.M., the DON said residents' call lights should always be in reach, even for a resident with a diagnosis of dementia. During an interview on 09/27/24, at 12:11 P.M., the Administrator said the residents' call lights should always be in reach, even for a resident with a diagnosis of dementia.

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F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents have reasonable access to and privacy in their use of communication methods. 42592 Based on interview and record review, the facility failed to ensure the right to privacy with communication when the facility opened two additional residents' (Resident #51 and #52) personal mail without permission. The facility census was 64. Review of the facility's policy, Mail and Electronic Communication, revised May 2017, showed the following: -Residents are allowed to communicate privately with individuals of their choice and may send and receive personal mail, email and other electronic forms of communication confidentially; -Mail will be delivered to the resident unopened; -Staff members of this facility will not open mail for the resident unless the resident requests them to do so (such request will be documented in the resident's plan of care). 1. During group interview on 09/16/24, at 1:05 P.M., two residents in attendance said they had received mail opened in the past few months and did not want to have their mail opened. Resident #51 said his/her mail was a financial statement and Resident #52 said his/her mail was personal mail. Neither resident said they had any restrictions on mail and neither resident gave the facility permission to open their mail. During an interview on 09/18/24, at 7:12 P.M., the Social Services Director (SSD) said the following: -Activity staff typically delivered the mail, but she would deliver if needed; -Sometimes the business office manager (BOM) would also help to deliver mail; -Mail should be delivered unopened unless the resident asked for it to be opened; -Resident #51 and #52 did not have any restrictions and should receive their mail unopened. During an interview on 09/18/24, at 7:25 P.M., the BOM said the following: -She helped deliver mail to the residents if the activity staff was not able to do it; -Mail was delivered unopened unless the resident asked for it to be opened. During an interview on 09/27/24, at 11:43 A.M., the Activity Director said the following: -She was responsible for delivering mail every day that she worked; -If she was not working, the activity aide delivered the mail; (continued on next page)

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F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Mail should be delivered unopened; -She did not recall delivering any mail opened. During an interview on 09/18/24, at 7:06 P.M., the administrator said the following: -Mail should be delivered unopened unless there was a specific reason for it to be opened; -Residents #51 and #52 should receive their mail unopened and had no restrictions.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38016 Based on observation, interview, and record review, the facility facility failed to provide documentation of a medical diagnosis that warranted the use of a restraint prior to initiation, assessment and monitoring for the use of physical restraints, including a wheelchair locked when placed up to the dining room table, a pommel cushion (a cushion with an upward-projecting protuberance at its front part that prevents a wheelchair dependent resident from sliding down and possibly falling out of a wheelchair), to prevent rising from a wheelchair, and a recliner positioned with he legs elevated (Resident #50 and #22), in a review of 24 sampled residents, who were in chairs to prevent them from rising. The residents could not easily and intentionally rise from their wheelchairs or a recliner. The facility did not document other interventions attempted or the consent of the resident or his/her representative. The facility census was 64. Review of the facility policy Use of Restraints, dated 01/30/24, showed the following: -Ensure that physical and/or chemical restraints are used only when needed to treat the resident's medical symptoms and then, only use the least restrictive alternative for the least amount of time. -It is this facility's policy to support each resident with attaining and maintaining his/her highest practicable well-being and ensure his/her dignity and quality of life in our building. This facility will not impose physical restraints for purposes of discipline or convenience. On rare occasions, it may be medically necessary to consider the use of a physical restraint and/or psychotropic medications; -Prior to the initiation of a physical restraint or psychotropic medication(s), clinicians will thoroughly assess the resident's mental/cognitive, behavior and physical status. This assessment will address other interventions that may be symptoms or the cause of the situation (e.g., identification of an infection process or delirium, presence of pain); -Documentation of assessment/evaluation and symptoms exhibited will be recorded in the resident's medical record; -Clinicians will consult with the attending physician, relaying assessment and observations; -Alternative and less restrictive measures to the use of a physical or chemical restraint, must be initiated and recorded, including effectiveness of any/all alternatives employed; -Clinicians and the attending physician must determine that a physical restraint is a measure of last resort to protect the safety of the resident or others. If there is no alternative to the use of a restraint, a physician's order is necessary for the initiation of any restraint or psychotropic medication; -That order will include the physician's diagnosis and include the medical symptoms prompting the need for such restraint; (continued on next page)

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Aspire Senior Living Moberly	700 East Urbandale Drive Moberly, MO 65270

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-It will also include the expected duration of the restraint; -Unless there is an actual emergency, a physical restraint or psychotropic medication will not be initiated until the need for such a restraint is discussed thoroughly with the resident and/or resident representative and written consent is obtained; -The resident/representative must be informed of potential risks and benefits of all options under consideration including using a restraint, not using a restraint and alternatives to restraint use; -The resident, or resident representative (if applicable), has the right to refuse the use of a restraint and may withdraw consent to use of the restraint at any time. If so, the refusal must be documented in the resident's record. The facility is expected to assess the resident and determine how resident's needs will be met if the resident refuses/declines treatment. -Documentation in the resident's medical record regarding the use of a restraint must include: -a. The length of time the restraint is anticipated to be used to treat the medical symptom, the identification of who may apply the restraint, where and how the restraint is to be applied and used, the time and frequency the restraint should be released, and who may determine when the medical symptom has resolved in order to discontinue use of the restraint; -b. The type of specific direct monitoring and supervision provided during the use of the restraint, including documentation of the monitoring; -c. The identification of how the resident may request staff assistance and how needs will be met during use of the restraint, such as for repositioning, hydration, meals, using the bathroom and hygiene; -d. The resident's record includes ongoing re-evaluation for the need for a restraint and is effective in treating the medical symptom; -e. The development and implementation of interventions to prevent and address any risks related to the use of restraint; -The resident's comprehensive care plan will reflect the resident's goals and the interventions/services needed for the safe use of a restraint as long as it is medically necessary; -Convenience is defined as the result of any action that has the effect of altering a resident's behavior such that the resident requires a lesser amount of effort or care and is not in the resident's best interest. Freedom of movement means any change in place or position for the body or any part of the body that the person is physically able to control; (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Indication for use is defined as the identified, documented clinical rationale for administering a medication that is based upon an assessment of the resident's condition and therapeutic goals and is consistent with manufacturer's recommendations and/or clinical practice guidelines, clinical standards of practice, medication references, clinical studies or evidence based review articles that are published in medical and/or pharmacy journals; -Medical symptom is defined as an indication or characteristic of a physical or psychological condition; -Physical restraint is defined as any manual method, physical or mechanical device, equipment, or material that meets all of the following criteria: -Is attached or adjacent to the resident's body; -Cannot be removed easily by the resident; -Restricts the resident's freedom of movement or normal access to his/her body; -Removes easily means that the manual method, physical or mechanical device, equipment, or material, can be removed intentionally by the resident in the same manner as it was applied by the staff. 1. Review of Resident #50's significant change in status Minimum Data Set (MDS), a federally mandated assessment completed by staff, dated 11/21/2023, showed the following: -Severe cognitive impairment; -Diagnosis of dementia and unspecified mood disorder; -Sometimes understands, responds to only adequately to simple, direct communication only; -Disorganized thinking present and fluctuates: resident thinking disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject); -No behaviors or rejection of care; -It was very important for the resident to have family involved in care; -Requires supervision/touching assistance from staff members for eating; -Requires partial/moderate assistance from staff for oral hygiene, toileting hygiene, shower/bathe, upper body dressing, lower body dressing, putting on/taking off footwear, personal hygiene, roll left and right, sit to lying, lying to sitting on side of bed; -Requires substantial/maximal assistance from staff for sit to stand, chair/bed-to-chair transfer, toilet transfer, tub/shower transfer, wheel 50 feet and wheel 150 feet; -Always incontinent of bowel and bladder; (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-No falls. Review of the resident's Care Plan, dated 05/06/24, showed staff observed the resident sitting on the floor on his/her buttocks. Staff added an intervention to assist the resident to a seated position if he/she is observed to be restless and attempting to transfer himself/herself without assistance. Review of the resident's Care Plan, dated 05/25/24, showed staff observed the resident on his/her floor in his/her room. Staff added an intervention to ensure the resident is sitting back and upright in his/her wheelchair to prevent him/her from sliding out of his/her wheelchair. Review of the resident's quarterly MDS, dated [DATE], showed the resident received antianxiety medication and had one no injury fall. Review of the resident's quarterly MDS, dated [DATE], showed the resident had one no injury fall. Review of the resident's Care Plan last reviewed 08/29/24 showed the following: -The resident is confused; -High risk for falls; -He/She was unsteady and needs assist of one to two staff members with his/her activities of daily living (ADLs), toileting and transfers; -Resident can be combative during cares; -Requires assist of one to two staff members with transfers (usually two) and he/she is propelled in his/her wheelchair by staff; -The resident attempts to ambulate without assistance at times., assist him/her to a seated position as allows if he/she is observed attempting to ambulate or stand up without assistance; -He/she is incontinent of bowel and bladder. The resident's medical record did not include a restraint assessment, consent for use of a restraint, interventions for safe use of restraints or any other direction to ensure release of restraints, or restraint monitoring. Observation on 09/15/24, at 3:27 P.M., showed the resident in the dining room in his/her wheelchair on the locked dementia unit. The resident's wheelchair was positioned where the seat of the wheelchair was towards the table with the armrest against the table, the wheelchair was locked. The table was bare, there were no items on the table in front of the resident. There was no staff in the dining room. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 09/15/24, at 5:05 P.M., showed the resident at the dining room table in his/her wheelchair in the locked dementia unit. The resident's food tray was located in front of him/her. The resident mumbled nonsensically and tried to push himself/herself back from the dining room table but his/her wheelchair would not move. The wheelchair was locked. The resident attempted to move his/her chair several times and said, Oh darn it. There was no staff present to monitor the resident in the dining room. Observation on 09/15/24, at 5:27 P.M., showed the resident at the same table dining room table. The resident's wheelchair continued to be locked with the chair up against the table. There were no staff in the dining room on the locked dementia unit. Observation on 09/15/24, at 5:36 P.M., showed the resident sat the dining room table. Certified Nurse Assistant (CNA) K was the only staff on the unit. CNA K stood over the resident and attempted to assist the resident to eat. The resident did not eat, and after a few minutes, the staff member left the dining room. The resident's wheelchair was locked while the resident sat with the arm rest of his/her wheelchair against the table. Observation on 09/15/24, at 6:22 P.M., showed the resident at the same table in the dining room on the locked dementia unit with his/her wheelchair locked and the arm rest against the table. The resident did not have any food or activities in front of him/her. Continuous observation from 09/16/24 at 10:40 A.M. until 11:20 A.M., showed the resident at the same dining room table on the locked dementia unit with the wheelchair brakes locked and the arm rest against the table. There were no items on the table. The resident had his/her head on the table with his/her eyes closed or was mumbling nonsensical sounds and rocking back and forth or in a circular motion during the observation. During an interview on 09/16/24, at 11:10 A.M., CNA O said the following: -The facility did not use restraints; -The resident's wheelchair was locked against the table to prevent him/her from standing up and walking; -The resident will get up and walk and when he/she goes to sit down, doesn't make sure a chair was there and will fall. Staff have to lock the resident's wheelchair up against the table until he/ she had time to walk with the resident. Observation on 9/16/24, at 4:45 P.M., showed the resident at the same table in dining room on the locked dementia unit with his/her wheelchair locked and the arm rest against the table. The resident repeatedly said, I'm tired, can I lay down? and would lay his/her head on the table. There were no staff monitoring the dining room. One staff member would walk into the dining room and then immediately leave. Observation on 9/17/24, at 8:45 A.M., showed the resident at the same table in dining room on the locked dementia unit with his/her wheelchair locked and the arm rest against the table. The table was bare. The resident sat by himself/herself in the dining room. No staff monitored the resident. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 9/17/24, at 4:00 P.M. showed the resident at the same table in dining room on the locked dementia unit with his/her wheelchair locked and the arm rest against the table. The table in front of the resident was bare. The resident would push against the table to move his/her wheelchair and the wheelchair would not move. No staff monitored the resident. During an interview on 9/17/24, at 4:05 P.M., CNA K said staff kept the resident's wheelchair locked at the table because if they sat the resident away from the table, on the couch or in the recliner, the resident would try to get up and walk. The resident could walk but when he/she decided to sit the resident would just sit down without a chair behind him/her and fall. Sitting him/her at the table with his/her wheelchair locked prevented the resident from falling. There were no residents on the unit with restraints. 2. Review of Resident #22's Face Sheet showed diagnosis include dementia with behaviors, Parkinson's disease (a disorder that affects movement - symptoms are slow movement, stiffness, and loss of balance), anxiety, depression, a history of a stroke, and an unspecified mood disorder. Review of the resident's Care Plan, dated 12/12/23, showed staff observed the resident on the floor in his/her room. Resident assessed to find a small bruise to right elbow and raised area/abrasion to forehead. Staff added the intervention to ensure the resident was positioned properly in the middle of his/her bed. His/Her bedside dresser was moved from the side of the resident's bed/recliner and a cushion placed in his/her recliner chair to stabilize the resident. Review of the resident's Care Plan, dated 01/21/24, showed staff observed the resident on the floor related to tipping his/her recliner chair forward. Staff added an intervention to ensure the resident was properly positioned in his/her recliner chair. Review of the resident's annual MDS, dated [DATE], showed the following: -Severe cognitive impairment; -Diagnosis include dementia with behaviors, Parkinson's disease, anxiety, depression, and an unspecified mood disorder; -Usually understood, usually understands; -Moderately impaired vision with corrective lenses; -Requires substantial/maximal assistance from staff for eating, and to roll left and right; -Dependent on staff for toileting hygiene, shower/bathe, dressing, putting on/taking off footwear, sit to lying, lying to sitting on side of bed, sit to stand, chair/bed-to-chair transfer, toilet transfer, tub/shower transfer, and to wheel wheelchair; -Always incontinent of bowel and bladder; -One injury fall since last assessment; -Takes psychotropic medications including antianxiety and antidepressant medications; (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Restraints and a chair that prevented rising was not used. Review of the resident's Care Plan, last reviewed on 06/18/2024, showed the following: -At high risk for falls; -The resident was forgetful and confused with very poor vision, weak and unsteady. -Requires the assistance of one to two staff with transfer and ADL's; -He/she was incontinent of bowel and bladder; -History of falls and takes medications that increase the risk of falls; -Ensure the resident's call light is within reach at all times; -The resident has a history of putting himself/herself on the floor, taking off his/her clothes and crawling on the floor; -Ensure the resident has proper positioning in his/her wheelchair, bed and recliner chair; -Monitor the resident frequently; -Ensure the resident's bed was in the lowest position and fall matt is in place while in bed; -Assist the resident to a seated position when he/she was observed standing or attempting to transfer himself/herself; -Encourage resident to keep his/her wheelchair brakes on while he/she was not moving; -Educate the resident on the risks associated with crawling on the floor; -The resident's recliner chair sat on a wider board base to help prevent tipping the recliner chair over. -Apply a pommel (a cushion applied in the seat of a wheelchair with a raised area that sits between the residents legs that can prevent the resident from rising or sliding) cushion in my high back reclining wheelchair and a footboard to the resident's foot rest. The resident's medical record did not include a restraint assessment, consent for use of a restraint, interventions for safe use of restraints or any other direction to ensure release of restraints, or restraint monitoring. Observation on 09/16/24, at 11:08 A.M., showed the resident in the dining room on the locked dementia unit in his/her high-back wheelchair with a pommel cushion. The resident was reclined with his/her feet elevated. The resident had a neck pillow around his/her neck and had his/her head down with eyes closed. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/16/24, at 11:10 A.M., CNA O said the resident had a pommel seat and was reclined because he/she had behaviors and tried to get up by himself/herself. Observation on 09/16/24, at 4:47 P.M., showed the resident in his/her room in a recliner. The resident's feet were elevated high in the chair. The base of the chair was connected to a large wooden base on the floor. The resident's call light was across the room and clipped high up on the curtain that divided the room. There are no staff or visitors in the resident's room During an interview on 09/16/24, at 4:47 P.M., the resident said he/she used his/her call light to call for help if he/she can find it. The resident said he/she could not put the feet down on his/her recliner. (The recliner foot rest was elevated.) He/She would rather be in bed than stuck in this chair. During an interview on 09/17/24, at 4:05 P.M., CNA K said the resident yelled out and got restless at times. The resident will wiggle around in the recliner but could not get out of the recliner without staff assistance. There were no restraints used on the unit. Observation on 09/17/24, at 4:08 P.M., showed the resident in his/her room in a recliner. The resident's feet were elevated high in the chair. During an interview on 09/18/24, at 09:00 A.M., the Director of Nursing said the following: -The facility did not use any restraints at this time; -She did not know staff were locking Resident #50's chair up next to the table; -Resident #22 has some of the devices to protect his/her skin and interventions to prevent falls; -If a restraint was going to be used staff were expected to assess the restraint and follow the policy for proper use and monitoring of restraints to ensure resident's needs are met and restraints are used appropriately.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 47246 Based on interview and record review, the facility failed to identify that one employee had a previous criminal offense as identified on a Criminal Background Check (CBC) through the Family Care Safety Registry (FCSR), that would have prohibited his/her employment, and allowed Housekeeper H continued resident contact through his/her employment at the facility. The facility census was 64. Review of the undated facility document, titled Department of Health and Senior Services, Can't Hire and Can Hire, showed the Can't Hire column included burglary, first degree, class B felony (S569.160). Review of the facility policy and procedure, Criminal Background Checks, revised 08/21/24, showed the following: -Purpose: Ensure compliance with state and federally required criminal background checks needed to provide a safe environment for residents, staff, and visitors; -All prospective employees must undergo criminal background checks before being hired; -All background checks will be conducted annually; -The background checks cover various offenses, including felonies, misdemeanors and certain offenses that may disqualify an individual from employment; -Disqualifying offenses: individuals with certain criminal convictions are disqualified from working in long-term care (LTC) facilities; -Disqualifying offenses generally include theft and financial exploitation crimes; -Missouri has specific statutes that govern criminal background checks for LTC facilities, such as Missouri Revised Statutes Chapter 660 (Section 660.317), which outlines the requirements and procedures for background checks in the context of elder care; -These policies ensure that the facility maintains a safe environment for vulnerable residents by employing individuals who meet the state's standards for criminal history. 1. Review of Housekeeper H's employee file showed the following: -He/She was hired on 03/27/23; -A FCSR background check was completed on 03/16/23 and showed the employee had a history of a conviction for first degree burglary, class B felony; -A FCSR background check was completed again on 06/26/24 and showed the employee had a history of a conviction for first degree burglary, class B felony (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The employee did not have a good cause waiver (GCW, a determination that an applicant's employment restrictions can be waived if they don't pose a risk to the health or safety of clients, patients, or residents. A GCW can apply to individuals who have been disqualified from working for regulated health care employers such as long-term care facilities). During an interview on 09/16/24 at 1:45 P.M. and 3:50 P.M., the Business Office Manager (BOM) said the following: -She was responsible for completing and reviewing the background checks on potential new employees for the facility, and this included the FCSR; -If there was a potential issue that would prohibit the facility from hiring a person, she would bring that to the attention of the administrator, Director of Nurses (DON), and the department head of the area the person had applied for; -If a prospective employee had a criminal background, she used a laminated check list from the Department of Health and Senior Services (Can Hire, Can't Hire list) to help her identify which criminal offenses would prohibit the facility from hiring someone; -She remembered seeing the employee's criminal background check but was not sure how she missed the criminal offense that prohibited his/her hiring; -The facility had two sets of eyes on checking the criminal backgrounds of prospective employees, so she was not sure how the employee's criminal history was missed; -The employee did not have a good cause waiver in place. During an interview on 09/16/24 at 2:30 P.M., the Director of Housekeeping said the following: -She reviewed applications from prospective employees when it indicated an interest in a housekeeping or laundry position; -It was up to the BOM to tell her if a potential employee had a criminal background check that was concerning or that would prohibit the hiring of that person; -If there was a concern on the criminal background check, she spoke to the administrator about those, and it was a joint decision if the facility hired the individual; -If the criminal offense was something that prohibited the facility from hiring the individual, then the administrator made that call; -She remembered looking at the employee's past criminal history when he/she was hired but did not remember what was on it; -She was familiar with what a good cause waiver was but was not aware of any facility employee who had one. During an interview on 09/16/24 at 2:50 P.M., the Administrator said the following: (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The BOM was responsible for completing a background check on all prospective employees for the facility; -If there was a concern on the background check of a prospective employee, the BOM would bring that to her attention, and she would review it as well; -The facility had a list from the Department of Health and Senior Services that was used for hiring that showed a column with can't hire and can hire based on a positive criminal background check; -She was not aware the employee had a criminal offense that prohibited him/her from working at the facility; -She was not sure how the employee's criminal background that was positive for a class B felony, first degree burglary was missed on his/her hiring and on his/her yearly background check; -The facility always had at least two people who reviewed the background checks for any concerns, usually it was the BOM and her, sometimes the DON as well, so she was not sure how this slipped through.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50189 Based on interview and record review, the facility failed to develop a person-centered comprehensive care plan specific to the resident, for two residents (Resident #42 and #36), in a review of 24 sampled residents. The facility census was 64. Review of the facility policy, Care Plans, Comprehensive Person-Centered, revised March 2022, showed the following: -The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident; -The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment; -The comprehensive, person-centered care plan: a. Includes measurable objectives and timeframes; b. Describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; c. Includes the resident's stated goals upon admission and desired outcomes; d. Builds on the resident's strengths; e. Reflects currently recognized standards of practice for problem areas and conditions; -Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making; -Assessments of residents are ongoing and care plans are revised as information about the residents and the resident's conditions change. 1. Review of Resident #42's Face Sheet showed the resident's diagnoses included hemiplegia (paralysis of one side of the body) and hemiparesis (muscle weakness or partial paralysis on one side of the body) following a stroke affecting the non-dominant left side, need for assistance with personal care, and partial loss of teeth. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 06/06/24, showed the following: -Cognitively intact; (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire Senior Living Moberly	700 East Urbandale Drive Moberly, MO 65270

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Required partial assistance for oral hygiene. Review of the resident's Dental Note, dated 07/24/24, showed the following: -The resident had marginal inflammation and bleeding following scaling of moderate plaque and light debris; -The resident had poor oral hygiene; -The resident needed someone to brush his/her teeth twice daily, with focus along the gumline. Review of the resident's annual MDS, dated [DATE], showed the following: -Cognitively intact; -Required partial assistance for oral hygiene. Review of the resident's Care Plan, revised 09/12/24, showed the following: -The resident had left sided hemiplegia; -The resident was mostly dependent on one to two staff for ADLs; -Staff will assist the resident with ADLs to keep the resident clean, dry and well-groomed; -The resident had a history of 13 dental extractions; -The resident had his/her own teeth. (The resident's care plan did not identify the resident needed assistance with oral hygiene including recommendations from the resident's dentist to ensure proper dental care.) During an interviews on 09/16/24 at 12:42 P.M. and on 09/17/24 at 4:33 P.M., the resident said staff do not offer to brush his/her teeth. He/She was unsure of the last time staff brushed his/her teeth. Review of the resident's Dental Note, dated 09/18/24, showed the following: -The resident had moderate plaque and debris; -The resident had poor oral hygiene; -The resident needed someone to brush or help brush his/her teeth twice a day with focus along the gum line. 2. Review of Resident #36's quarterly MDS, dated [DATE], showed the following: -Moderate cognitive impairment; (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Required substantial assistance from staff for oral hygiene. Review of the resident's Care Plan, revised 07/11/24, showed the following: -The resident required assistance from one to two staff for all ADLs; -The staff should assist the resident with all ADLs and keep him/her clean, dry and well-groomed; -The resident had his/her own teeth. (The resident's care plan did not identify the resident needed assistance with oral hygiene including recommendations from the resident's dentist to ensure proper dental care.) Review of the resident's Dental Note, dated 08/14/24, showed the following: -The resident's oral hygiene was poor; -The resident had heavy plaque and moderate calculus; -The resident should have his/her teeth brushed twice daily and flossed once daily. Review of the resident's Dental Note, dated 09/18/24, showed the following: -The resident had poor oral hygiene; -The resident had marginal inflammation and bleeding following scaling and brushing of moderate plaque, and light to moderate calculus; -The resident required someone to brush, or help brush, his/her teeth twice daily, with focus along the gumline. During an interview on 09/18/24 at 8:28 A.M., the resident said staff only brush his/her teeth on his/her shower days twice a week. 3. During interviews on 09/18/24 at 7:03 P.M. and 10/02/24 at 4:34 P.M., the MDS Coordinator said the following: -She was responsible for developing the care plans; -She obtained the information needed for the care plans through brief resident interviews, physician orders, outside records (like dental notes), and the MDS; -Other staff contributed information, but they presented it to her and she added it to the care plan; -Staff was responsible for understanding that ADLs on the care plan included oral hygiene, face washing, hair brushing, shaving, and getting dressed; (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-She listed the general type of assistance the residents needed with ADLs. She did not break the type of assistance the residents needed for each specific ADL; -If a resident needed more or less assistance with a specific ADL than what was identified in the general statement in the care plan, she would list the specific ADL and type of assistance needed; -The general type of assistance needed for ADLs was listed on all the residents' care plans. Staff should follow the care plan and facility policy for providing all ADL care; -Resident #42 was dependent on one to two staff for all ADLs per his/her care plan, so staff should assist the resident with oral hygiene care, morning and night, per the facility policy; -Resident #36 was dependent on one to two staff for all ADLs per his/her care plan, so staff should assist the resident with oral hygiene care, morning and night, per the facility policy. During an interview on 09/27/24 at 11:34 A.M., the Director of Nursing (DON) said the following: -The MDS Coordinator was responsible for developing the care plans; -The MDS Coordinator conducted resident interviews, reviewed physician notes and orders and nursing progress notes to determine what needed to be on the care plan; -ADLs should be included on the care plan and it should list the overall ADL assistance a resident required. At this time, the care plan did not break it down into specific needs for each ADL. During an interview on 09/25/24 at 3:45 P.M., the Administrator said she expected the residents' ADL needs to be listed on the residents' care plans, at minimum an overall ADL assistance. If the type of assistance differed from their overall need, the care plan should be specific and individualized.

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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 - Few	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** 50189 Based on observation, interview, and record review, the facility failed to ensure staff provided two residents (Resident #42 and #36), who required assistance to complete their own activities of daily living (ADL), in a review of 24 sampled residents, the necessary care and services to maintain good oral hygiene. The facility census was 64. Review of the facility policy, Dental/Oral Care of the Resident, dated 01/30/24, showed the following: -Purpose: to clean and freshen the resident's mouth, prevent infections of the mouth, maintain the teeth and gums in a healthy condition, stimulate the gums and remove food particles from between the teeth; -Assist the resident with brushing their teeth based on individual needs; -Teeth should be brushed every morning and evening; -Flossing of the teeth should be done at least once a day to promote healthy gums; -Inspect the gums for any paleness, discoloration, bleeding sores or irritation; -Inspect the teeth for decay or looseness; -Report and document any issues with the resident's mouth, gums and/or teeth to the charge nurse and attending physician. 1. Review of Resident #42's Face Sheet showed the resident's diagnoses of hemiplegia (paralysis of one side of the body) and hemiparesis (muscle weakness or partial paralysis on one side of the body) following a stroke affecting the non-dominant left side, need for assistance with personal care, and partial loss of teeth. Review of the resident's Dental Note, dated 04/03/24, showed the following: -The resident had heavy plaque (sticky, white film) and calculus (hardened, solidified plaque with a yellowish color); -The resident had red marginal gingivitis (a gum disease that is a result of bacterial buildup on the teeth causing irritation to the surrounding gum tissue and can cause the gums to become inflamed, discolored, and painful); -The resident may need additional extractions; -The resident needed oral hygiene improvement before treatment or extractions can be done; -The resident needed follow ups every three months. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's Dental Note, dated 05/15/24, showed the following: -The resident had marginal inflammation (swelling) and bleeding following scaling (removal) of light to moderate plaque and minimal calculus buildup; -The resident had poor oral hygiene; -The resident needed someone to brush his/her teeth twice daily, with focus on the gumline. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 06/06/24, showed the following: -Cognitively intact; -No behaviors or rejection of care; -Impaired range of motion (ROM) in upper and lower extremities on one side; -Required partial assistance for oral hygiene. -No dental concerns. Review of the resident's Dental Note, dated 07/24/24, showed the following: -The resident had marginal inflammation and bleeding following scaling of moderate plaque and light debris; -Polish was not applied due to inflammation, bleeding, condition of enamel (the protective, outer coating of your teeth), and exposed root surface; -The resident had poor oral hygiene; -The resident needed someone to brush his/her teeth twice daily, with focus along the gumline. Review of the resident's Dental Note, dated 08/14/24, showed the following: -The resident had poor oral hygiene; -The resident had heavy plaque and calculus; -It was recommended the resident have three teeth extracted. Review of the resident's annual MDS, dated [DATE], showed the following: -Cognitively intact; -No behaviors or rejections of care; (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Impaired range of motion in upper and lower extremities on one side; -Required partial assistance for oral hygiene; -No dental concerns. Review of the resident's Care Plan, revised 09/12/24, showed the following: -The resident was mostly dependent on one to two staff for ADLs; -The resident had left sided hemiplegia; -Staff were to assist the resident with ADLs to keep the resident well-groomed; -The resident had a history of 13 dental extractions; -The resident had his/her own teeth; -No documentation of oral hygiene needs. During an interview on 09/16/24 at 12:42 P.M., the resident said the following: -He/She had some teeth the dentist said needed pulled (extracted); -The staff do not offer to brush his/her teeth; -He/She would like to have his/her teeth brushed at least once a day. Observation on 09/16/24 at 12:42 P.M. showed the resident had white plaque build up along the gum lines of his/her lower teeth. During an interview on 09/17/24 at 4:33 P.M., the resident said the following: -Staff did not brush or offer to brush his/her teeth today; -He/She was unsure of the last time staff brushed his/her teeth; -He/She was unsure where his/her tooth brush was. Observation on 09/17/24 at 4:33 P.M. showed the following: -The resident's tooth brush was located in the resident's top dresser drawer; -The toothbrush was in a bag with a tube of toothpaste; -There was no water or toothpaste residue in the bag or on the toothbrush; -The toothbrush was dry. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's Dental Note, dated 09/18/24, showed the following: -The resident had marginal inflammation and bleeding following scaling and brushing; -The resident had moderate plaque and debris and very light calculus; -The resident had poor oral hygiene; -The resident needed someone to brush or help brush his/her teeth twice a day with focus along the gum line; -The resident did not have polish applied due to inflammation, bleeding, condition of enamel, and exposed root surface. During an interview on 09/18/24 at 9:51 A.M., the resident said staff did not brush or offer to brush his/her teeth today or last night. Observation on 09/18/24 at 9:51 A.M. and 1:44 P.M. showed the following: -The resident's toothbrush was in the same place in the resident's top dresser drawer; -The toothbrush was in a bag with a tube of toothpaste; -There was no water or toothpaste residue in the bag or on the toothbrush; -The toothbrush was dry. 2. Review of Resident #36's face sheet showed the resident's diagnoses included dementia and muscle weakness. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Moderate cognitive impairment; -No behaviors or rejection of care; -Required substantial assistance from staff for oral hygiene; -No dental concerns. Review of the resident's care plan, revised 07/11/24, showed the following: -The resident required assistance from one to two staff for all ADLs; -The staff should assist the resident with all ADLs and keep him/her clean, dry and well-groomed; -The resident has his/her own teeth. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's Dental Note, dated 08/14/24, showed the following: -The resident's oral hygiene was poor; -The resident had heavy plaque and moderate calculus; -The resident should have his/her teeth brushed twice daily and flossed once daily. During an interview on 09/17/24 at 6:46 A.M., Certified Nurse Aide (CNA) G said the following: -He/She did not offer to brush the resident's teeth after he/she got the resident up and washed his/her face because the resident was going to breakfast; -He/She always offered to brush the resident's teeth during showers; -The resident was on his/her shower list for today, so he/she would offer to brush the resident's teeth then. During an interview on 09/18/24 at 1:45 P.M., CNA C said the following: -He/She did not brush the resident's teeth when he/she got the resident up on 9/17/24 as it was time for breakfast; -The resident was on the shower schedule for 9/17/24 and the shower aide would offer to brush the resident's teeth then. Review of the resident's Dental Note, dated 09/18/24, showed the following: -The resident had poor oral hygiene; -The resident had marginal inflammation and bleeding following scaling and brushing of moderate plaque, and light to moderate calculus; -The resident did not have polish applied due to inflammation, bleeding, conditions of some enamel, and exposed root surface; -The resident required someone to brush, or help brush, his/her teeth twice daily, with focus along the gumline. Observation on 09/18/24 at 8:28 A.M. showed the resident had white plaque buildup along the bottom of his/her lower teeth, near the gumline. During an interview on 09/18/24 at 8:28 A.M., the resident said the following: -Staff did not brush his/her teeth today; -Staff only brush his/her teeth on shower days; (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Shower days were two times per week. 3. During an interview on 09/27/24 at 11:34 A.M., the Director of Nursing (DON) said the following: -Staff should brush residents' teeth in the morning and the evening; -Staff should always try and encourage residents to brush their teeth; -Resident #42 had refused oral hygiene in the past, but she was not aware of any recent refusals; -Any staff who get the residents up in the morning or get them ready for bed at night should offer and provide oral hygiene; -He/She expected staff to offer and provide oral hygiene twice per day if the resident would allow it; During an interview on 09/25/24 at 3:45 P.M., the Administrator said the following: -Staff should brush the residents' teeth at least twice a day; -The CNAs were responsible for ensuring oral hygiene was offered and provided.

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38016 Based on observation, interview, and record review, the facility failed to design a meaningful activity program to meet the needs and interests of six residents (Residents #3, #4, #21, #22, #30 and #50), in a review of 24 sampled residents. The facility failed to provide activities to the residents at a frequency consistent with their plan of care and activity assessment, and failed to provide a structured activities program to three residents (Residents #21, #22 and #50) on the memory care unit focused on the individualized needs of the residents to keep them engaged in meaningful activities. The facility census was 64. Review of the facility's policy, Activity Program, dated 01/30/24, showed the following: -Activities refer to any endeavor, other than routine ADLs, in which a resident participates that is intended to enhance his/her sense of well-being and to promote or enhance physical, cognitive, and emotional health. These include, but are not limited to, activities that promote self-esteem, pleasure, comfort, education, creativity, success, and independence. -Provide a wide range of activities to enhance the lives of residents; -Provide opportunities for residents and staff to interact on a social basis; -Activities will be scheduled on a regular basis to enrich the lives of residents. Activities will include, but are not limited to: a. Social events; b. Indoor and outdoor activities; c. Activities outside of the facility; d. Religious programs; e. Creative activities; f. Intellectual and educational activities; g. Exercise activities; h. Individualized activities; i. In-room activities; j. Community activities; -Individualized and group activities are provided that; (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. Reflect the schedules, choices, and rights of the residents; b. Are offered at hours convenient to and preferred by the residents, including holidays and weekends; c. Reflect the cultural and religious interests of the residents; d. Appeal to both men and women as well as all age groups of residents residing in the facility; -Residents are encouraged but not forced to participate in scheduled activities. Review of the facility's policy, Types of Activity Programs, dated 01/30/24, showed the following: -Activity programs will be provided to support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community; -This facility's Activity Program incorporates the resident's interests, hobbies, and cultural preferences to create opportunities for each resident to have a meaningful life by supporting his/her domains of wellness, security, autonomy, growth, connectedness, identity, joy and meaning; -Diversional activities, for both male and female residents, are provided to place emphasis on accomplishment rather than sociability and fun, although residents may have fun and find the activity enjoyable; -Diversional activities include, but are not limited to: i. Braiding rugs; ii. Sewing, quilting, etc.; iii. Painting; iv. Refinishing furniture; v. Repairing or making toys, etc.; -Group activities, the involvement of a number of people in physical and mental interaction, are vital to the effectiveness of the activity program; -Group activities maximize resources, involve many people, and promote social interaction; -These activities are encouraged to assist residents in overcoming feelings of loneliness, isolation, and self-pity, which often accompany long-term care and illness; -Group activities are divided into four categories: i. Spectator; (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ii. Performing; iii. Independent/Individual; iv. Interdependent; -Residents are encouraged to participate in all group activities, but especially those where they are best able to participate physically, mentally, and emotionally; -Individual activities are provided because residents have a need for personal identity. Some residents are unable to or do not wish to participate in group activities; -For those residents whose physical disabilities prohibit movement to a group activity, or those who do not wish to participate in group activities, the individual activity program provides; -Activities which make maximum use of each resident's physical and mental abilities; -Activities which are interesting to and involve the resident and which present a challenge that can be met by the resident; -For residents who have severe emotional problems or who are not alert enough to become part of a group, the individual program of activities includes: a. Activities which are basically uncomplicated, but which can become more elaborate to accommodate increased ability, such as making yarn animals or playing games; b. Short periods of concentration to avoid frustration; c. Enough time for the activity department to develop a close relationship with the resident involved so that activity personnel will be able to regain the resident's attention should his or her mind wander; -Intellectual activities are encouraged and are designed to stimulate the resident's mind. These activities include, but are not limited to participation in discussion groups, clubs, and committees; voting; book reviews/clubs; sketching; drama; music appreciation; current events, etc.; materials such as talking books, records and films are available from the local library as well as other resources; -Social activities are scheduled to help minimize self-consciousness, increase self-confidence, and stimulate interest and friendships by providing fun and enjoyment for those who take part; -Social activities may include, but are not limited to square, folk, and round dancing; group singing; horseshoes; adapted bowling; charades; cards; checkers, bingo, board games; birthday/holiday parties, etc; (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Recreational activities with an emphasis on social aspects include outings to places of interest (e.g., historic places, museums, ball games, fairs, parks, etc.); participation in community groups and religious organizations. This type of activity will encourage residents to be more active in the community setting; -Spiritual and Religious Activities: a. Various types of spiritual and religious activities are available and scheduled through local churches and ministers; b. Residents are encouraged to attend religious activities of their choice. These activities may include, but are not limited to worship services, singing, bible teaching, and bible reading; -Residents are always given freedom of choice in attending spiritual and religious activities and are never forced to attend; -Resident requests for private consultation with clergymen are always honored; -Alternative activity programs may be scheduled simultaneously with religious services for those residents who wish to attend non-religious programs; -Activities for Residents with Dementia: a. All residents have a need for engagement in meaningful activities. For residents with dementia, the lack of engaging activities can cause boredom, loneliness and frustration resulting in distress and agitation; b. Activities must be individualized and customized based on the resident's previous lifestyle (occupation, family, hobbies), preferences and comforts. 1. Review of Resident #3's Face Sheet showed the resident's diagnoses included Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions), vascular dementia (brain damage caused by multiple strokes), major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life) and anxiety disorder (a mental health disorder characterized by feelings of worry or fear that are strong enough to interfere with daily activities). Review of the resident's annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 03/28/24, showed the following: -Severely impaired cognition; -Activities very important to the resident included listening to music he/she liked and attending favorite activities; -Activities somewhat important to the resident included doing things with groups of people and going outside for fresh air when weather was good; (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire Senior Living Moberly	700 East Urbandale Drive Moberly, MO 65270

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Activities that are not very important include: being around animals such as pets and participating in religious services or practices; -Activities that are not important at all include: reading books, newspapers or magazines and keeping up with the news. Review of the Resident Interview Section F Preferences, dated 06/21/24, showed the following interview for activity preferences: -Very important to listen to music, keep up with the news, do things with groups of people, and do favorite activities; -Not very important to be around animals/pets, go outside when good weather, participate in religious practices; -Not important at all: have books/newspapers/magazines to read; -Comments: The resident was encouraged to join group activities. He/She will occasionally get a manicure or social hour; -The resident was the primary respondent for activity preferences; -When the resident did not join activities and groups, he/she had one-on-one visits. Review of the resident's Activity Assessment, completed on 06/25/24, showed the following: -Resident awake all or most of the morning; -Most common use of resident's time: visiting with family, watching TV, and napping; -Average time in activities: little - less than 1/3 of time; -Preferred activity settings: own room, day/activity room and inside facility and off unit; -Special talents/hobbies: loves soda and sour tea; -Resident's preferred program style: one-on-one; -Program frequency: three times a week; -General activity preferences: music, watching TV and talking/conversing; -Focus of programming: one-on-one activities, group games, independent activities, relaxation activities and social interaction activities; -Activity Care Plan is place. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's One-to-One Activities Log for the week of 7/7/24 through 7/13/24 showed the following: -07/09/24: length of visit: 15 minutes. Activity: discussion/conversation. Participant response: offered him/her a peach tea, explained to him/her the flavor, he/she tasted it and said, yuck, sour tea; -07/10/24: length of visit: 10 minutes. Activity: grooming. Participant response: resident was cold, got him/her a blanket, he/she was happy. We watched TV. (No documentation the resident attended a group activity, and no documentation staff offered or provided at least three activities for the resident as directed in his/her activity assessment during the week of 7/7/24 through 7/13/24.) Review of the resident's Care Plan, reviewed on 7/11/24, showed the following: -The resident would benefit from interactions with others during group activities; -Goal: he/she will participate in activities of choice at least two times weekly; -Interventions: explain activities that will be offered daily. Invite him/her to all activities and assist him/her to activities of choice. The resident enjoys watching TV, listening to music and attending special events. Provide him/her with one-on-one visits as needed for added support and socialization. Review of the resident's One-to-One Activities Log for the week of 7/14/24 through 7/20/24 showed the following: -07/14/24: length of visit: 7 minutes. Activity: grooming. Participate response: invited and helped him/her come to prayer group, he/she drank coffee and was ready to leave; -07/19/24: length of visit: 30 minutes. Activity: music. Participant response: resident loved the music and smiled the whole time. (No documentation the resident attended at least three activities, including one-on-one activities, during the week of 7/14/24 through 7/20/24.) Review of the resident's One-on-One Activities Log for the week of 7/21/24 through 7/27/24 showed the resident participated in one activity on 7/22/24. The staff asked the resident if he/she wanted ice cream and the resident asked for sour tea instead. (No documentation the resident attended a group activity, and no documentation staff offered or provided at least three activities for the resident as directed in his/her activity assessment during the week of 7/21/24 through 7/27/24.) Review of the resident's One-to-One Activities Log for the week of 7/28/24 through 8/3/24 showed the following: -08/01/24: length of visit: 15 minutes. Activity: discussion/conversation. Participant response: read the calendar to the resident; (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-08/03/24: length of visit: 10 minutes. Activity: discussion/conversation. Participant response: encouraged resident to join group for watermelon, he/she got watermelon. (No documentation staff offered or provided at least three activities for the resident as directed in his/her activity assessment during the week of 7/28/24 through 8/3/24.) Review of the resident's One-to-One Activities Log for the week of 8/11/24 through 8/17/24 showed the following: -08/11/24: length of visit: 10 minutes. Activity: sensory stimulation (no specific type identified). Participant response: the resident got cake from the birthday party; -08/14/24: length of visit: 15 minutes. Activity: discussion/conversation. Participant response: Got the resident and soda and talked about it being the best drink. (No documentation staff offered or provided at least three activities for the resident as directed in his/her activity assessment during the week of 8/11/24 through 8/17/24.) Review of the resident's One-to-One Activities Log for the week of 8/18/24 through 8/24/24 showed the following: -08/19/24: length of visit: 15 minutes. Activity: grooming. Participant response: resident joined manicures but refused polish and listened to music; -08/22/24: length of visit: 10 minutes. Activity: grooming. Participant response: resident wanted his/her shoes on so got shoes on his/her feet and pushed the resident in dining room to talk with friends. (No documentation staff offered or provided at least three activities for the resident as directed in his/her activity assessment during the week of 8/18/24 through 8/24/24.) Review of the resident's One-on-One Activities Log for August 2024 showed no documentation the resident participated in any activities during the week of 8/25/24 through 8/31/24. Observation on 09/15/24 at 3:52 P.M., showed the resident sat in his/her room in front of the TV. Observation on 09/16/24 at 11:05 A.M., showed staff provided residents with manicures as the scheduled activity in the dining room. The resident was not in the dining room for the activity. Observation on 09/16/24 at 2:30 P.M., showed staff provided yoga as the scheduled activity in the dining room. The resident was not in the dining room for the activity. Observation on 09/18/24 at 8:30 A.M., showed the resident sat in his/her room in front of the TV. During an interview on 10/02/24, at 8:32 A.M., the Activity Director said the following: -Activities for the resident included some group activities like manicures and bingo, but the main activity for the resident was one-on-one visits; (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident liked to talk about college days and his/her shoes and liked to watch TV; -She saw the resident every day she was at the facility and read the activity schedule to the resident. 2. Review of Resident #4's undated Continuity of Care Document (CCD) showed the following: -Diagnoses included anxiety disorder, depression (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life) and legal blindness; -He/She would participate in activities of choice at least two times weekly through next review. Review of the resident's annual MDS, dated [DATE], showed the following: -Cognitively intact; -Minimal hearing difficulty with clear speech; -Able to make self-understood and understood others; -Moderately impaired vision - can identify objects; -Feeling down, depressed or hopeless; -Mild depression; -Activities that were very important to the resident included having books to read (listen to), keeping up with the news, attending favorite activities and going outside when the weather is good; -Activities that were somewhat important to the resident included snacks and music. Review of the resident's One-to-One Activities Log for the week of 7/07/24 through 7/13/24 showed the resident only participated in an activity on 7/10/24. The activity was cooking club. Staff told the resident they would bring him/her the cowboy hat made during the activity. The resident loved the cowboy hat and asked how it was made. He/She had to guess what the ingredients were. (No documentation staff offered or provided at least two activities for the resident as directed in his/her care plan during the week of 7/07/24 through 7/13/24.) Review of the resident's Activity Assessment, dated 07/26/24, showed the following: -Resident awake all or most of the morning; -Most common use of resident's time: listening to audio books; -Average time in activities: little - less than 1/3 of time; -Preferred activity settings: own room and day/activity room; (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Special talents/hobbies: listening to audio books; -Resident's preferred program style: 1:1 and large groups; -Program frequency: the resident loves audio books, being outside and entertainers; -Program time preference: afternoon; -Participation barriers: sight; -General activity preferences: music and talking/conversing; -Focus of programming: 1:1 activities, creative/expressive activities, intellectually stimulating activities, outdoor activities, relaxation activities and social interaction activities; -Sensory Stimulation: 1:1 and group; -Reality orientation: 1:1 and group; -Validation: 1:1 and group; -Describe other programming, if necessary: the resident is blind, he/she needs assistance always; -Activity Care Plan is place. Review of the resident's One-to-One Activities Log for the week of 7/28/24 through 8/3/24 showed the following: -7/29/24, staff painted the resident's nails in his/her room; -08/01/24: length of visit: 15 minutes. Activity: discussion/conversation. Participant response: read the calendar for the month; -08/02/24: length of visit: 10 minutes. Activity: sensory stimulation (no type indicated). Participant response: encouraged the resident to stay awake. (No documentation the staff provided at least two meaningful activities for the resident during the week of 7/28/24 through 8/3/24. Staff read the calendar to the resident and encouraged the resident to stay awake during a visit. The resident only participated in one activity where staff painted his/her nails.) Review of the resident's One-on-One Activities Log for the week of 8/04/24 through 8/10/24 showed on 8/08/24, staff painted the resident's nails. (No documentation staff offered or provided at least two activities for the resident during the week of 8/04/24 through 8/10/24.) (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's One-on-One Activities Log for the week of 8/18/24 through 8/24/24 showed the resident was up to smoke. Activity staff talked to the resident about lunch and helped him/her to the dining room. (No documentation staff provided at least two meaningful activities for the resident during the week of 8/18/24 through 8/24/24.) Review of the resident's One-on-One Activities Log for the week of 8/25/24 through 8/31/24 showed the following: -08/26/24: length of visit: 15 minutes. Activity: discussion/conversation. Participant response: encouraged resident to stay up for nails; he/she fell asleep; -08/28/24: length of visit: 10 minutes. Activity code: blank. Participant response: resident wanted to go to group coffee chat and snack, but he/she went to smoke. (No documentation the staff provided at least two meaningful activities for the resident during the week of 8/25/24 through 8/31/24.) Observation on 09/15/24, at 6:55 P.M., showed the resident lay in bed with a stocking cap pulled down over eyes. The resident wore head phones that were connected to a book on tape. Observation on 09/16/24, at 9:55 A.M., showed the resident lay in bed with a stocking cap pulled down over eyes. The resident wore head phones that were connected to a book on tape. Observation on 09/16/24 at 11:05 A.M., showed staff provided residents with manicures as the scheduled activity in the dining room. The resident was not in the dining room for the activity. Observation on 09/16/24 at 2:30 P.M., showed staff provided yoga as the scheduled activity in the dining room. The resident was not in the dining room for the activity. During an interview on 09/16/24, on 4:25 P.M., the resident said the following: -He/She had poor eyesight and did not want to have the staff help him/her during activities because it took away from other people to help him/her; -He/She enjoyed being around activities to just hear the conversations and could possibly make a new friend; -He/She mostly stayed in his/her room and listened to books on tape since he/she cannot see well; -He/She had not been getting up out of bed for smoking, meals or activities because his/her wheelchair caused him/her discomfort and pain. Review of the resident's Care Plan, revised 09/17/24, showed the following: -He/She was on medications for depression and anxiety. -He/She would benefit from interactions with others during group activities; (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She will participate in activities of choice at least two times weekly through next review; -He/She enjoys audio books, manicures, listening to classical music, and going outdoors to smoke. Observation on 09/17/24 at 10:05 A.M., showed staff provided Bingo in the dining room as the scheduled activity. The resident was not in the dining room for the activity. During interviews on 09/27/24 at 11:43 A.M. and 10/02/24, at 8:32 A.M., the Activity Director said the following: -The resident participated in activities and went out to smoke if he/she was out of bed; -The resident did not like to get out of bed; he/she did not like to sit in his/her wheelchair because his/her body hurt; -The resident liked to talk, go outside to smoke, listen to books on tape, and manicures in his/her room; -Activities he/she provided for the resident included mainly manicures in his/her room and one-on-one visits; -She saw the resident every day she was at the facility and read the activity schedule to the resident; -She invited the resident to all groups during her morning talk, and the resident sometimes said he/she would attend and sometimes he/she refused; -When the resident refused activities, the resident would not typically give her a reason for the refusal; -She was unaware the resident wanted to attend more group activities. 3. Review of Resident #30's Face Sheet showed the resident's diagnoses included unspecified dementia (a type of dementia that does not have a specific diagnosis), depression, generalized anxiety disorder and unspecified mood affective disorder (mood disorder symptoms that are significant but do not meet the criteria for a specific mood disorder. Review of the resident's annual MDS, dated [DATE], showed the following: -Severe cognitive impairment; -Activities that were very important to the resident included listening to music and attending favorite activities; -Activities that were somewhat important to the resident included being around animals such as pets, doing group activities and going outside when the weather was good; -Activities that were not very important to the resident included keeping up with the news; (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Activities that were not important at all were religious services and/or practices. Review of the resident's One-to-One Activities Log for July 2024 showed no documentation staff offered or provided at least three activities for the resident on 7/1/24 through 7/13/24. Review of the resident's Activity Assessment, completed on 07/23/24, showed the following: -Awake all or most of the time in the afternoon; -Average time involved in activities: little - less than 1/3 of time; -Preferred activity settings: own room; -Preferred program style: one-on-one and large groups; -Program frequency: three one-on-one visits per week; -General activity preferences: music, walking/wheeling outdoors; -Focus of programming: one-on-one activities, relaxation activities, and social interaction activities; -Activity care plan in place. Review of the resident's One-to-One Activities Log for the week of 7/21/24 through 7/27/24 showed the following: -07/22/24: length of visit: 15 minutes. Activity: music. Participant response: played old country in the front area. -07/25/24: length of visit: 14 minutes. Activity: discussion/conversation. Participant response: tried to get resident to stay awake but he/she was tired. (No documentation staff offered or provided at least three activities for the resident as identified on his/her activity assessment during the week of 7/21/24 through 7/27/24.) Review of the resident's Care Plan, updated 08/01/24, showed the following: -He/She would benefit from interactions with others during group activities; -Goal: He/She will participate in activities of choice at least two times weekly through next review; -Approaches: Explain the activities that will be offered daily and invite him/her to all activities and assist with activities of his/her choice. The resident enjoys getting his/her nails done, holding and rocking his/her dolls, watching TV at times and socializing with spouse and visitors. Provide him/her with one-on-one visits as needed for increased socialization. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's One-to-One Activities Log for the week of 7/28/24 through 8/03/24 showed staff read the monthly calendar to the resident on 8/02/24. (No documentation staff offered or provided at least three meaningful activities for the resident during the week of 7/28/24 through 8/03/24.) Review of the resident's One-to-One Activities Log for the week of 8/11/24 through 8/17/24 showed the following: -08/13/24: length of visit: 10 minutes. Activity: reading material. Participant response: read him/her the menu and talked about the meal; -08/15/24: length of activity: 15 minutes. Activity: music. Participant response: music in dining room - old rock. (No documentation staff offered or provided at least three meaningful activities for the resident during the week of 8/11/24 through 8/17/24.) Review of the resident's One-to-One Activities Log for the week of 8/25/24 through 8/31/24 showed the following: -08/25/24: length of activity: 15 minutes. Activity: music. Participant response: Christian music in the front room; -08/26/25: length of activity: 15 minutes. Activity: grooming. Participant response: brushed hair and talked to him/her about lunch time. (No documentation staff offered or provided at least three activities for the resident during the week of 8/25/24 through 8/31/24.) Review of the resident's One-to-One Activities Log for 9/08/24 through 9/14/24 showed staff played soft jazz for the resident after lunch on 9/08/24. (No documentation staff offered or provided at least three meaningful activities for the resident during the week of 9/08/24 through 9/14/24.) Observation on 09/15/24, at 4:24 P.M., showed the resident lay awake in his/her bed facing the wall. Observation on 09/16/24, at 9:37 A.M., showed the resident lay awake in his/her bed facing the wall. Observation on 09/16/24, at 11:05 A.M., showed activity staff in the dining room painting residents' nails. The resident was not participant of that activity. He/She sat up in his/her wheelchair at the dining room table ready for lunch. Observation on 09/16/24, at 2:30 P.M., showed staff provided yoga as a group activity in the dining room. The resident lay in bed with his/her eyes closed during the activity. During an interview on 10/02/24, at 8:32 A.M., the Activity Director said the following: (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Activities for the resident included some group activities like music one time a month but mainly one-on-one visits; -The resident's family was very involved and many days the resident was too tired to talk to staff during one-on-one visit; -The resident liked to talk and she read to the resident; -She saw the resident every day she was at the facility and read the activity schedule to the resident. 4. Review of Resident #21's annual MDS, dated [DATE], showed the following: -Severe cognitive impairment; -Sometimes understands simple direct communication only; -Diagnoses included Alzheimer's disease, dementia, depression, and anxiety. -No wandering, behaviors or rejection of care; -Activity preferences very important to the resident: listen to music he/she likes, around animals/pets, go outside, and religious activities; -It is somewhat important to keep up with news and do things with groups, Review of the resident's quarterly MDS, dated [DATE], showed the following: -Added a diagnosis of unspecified psychosis; -No devices used (wheel chair and /c walker); -Requires supervision/touching assistance from staff for eating, roll left and right, on side of bed, sit to stand, walk 10 feet, walk 50 feet with two turns, walk 150 feet with two turns, walk 150 feet. Review of the resident's One-to-One Activities Log for 07/01/24-07/15/24, showed the following: -07/01/24: length of visit: 15 minutes. Activity: sensory. Participant response: Exercised up and down the hall. -07/02/24: length of visit: 6 minutes. Activity: music. Participant response: resident was tired but listed to Amazing Grace; -07/09/24: length of visit: 10 minutes. Activity: reading material. Participant response: read the menu to the resident and held his/her hand. The resident was sad. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-07/12/24: length of visit: 10 minutes. Activity: games. Participant response: played old classic music to see if the resident recognized the music and he/she loved it. -07/13/24: length of visit: 15 minutes. Activity: discussion/conversation. Participant response: listened to Gun Smoke; -No activities documented from 7/14/24-7/19/24. Review of the resident's Activity Assessment, dated 07/16/24, showed the following: -The resident was awake most of the morning, afternoon and evening; -The most common use of the resident's time was visiting with family or staff; -Less than 1/3 to 1/2 of his/her time when awake was spent on activities; -Talents/hobbies: enjoys music; -Prefers activities in his/her own room, day/activity room, and inside nursing home/off unit; -Program style is one-on-one activities, small and large groups; -Program frequency: three or more times a week; -Prefers activities in the morning and afternoon, -Communication and short-term memory is a problem; -Leisure interest are crafts/arts, exercise, music, religious activities and walking outdoors; -Activity preferences are music or talking/conversing; -Focus programming on one-on-one visits, group games, independent activities, intellectually stimulating activities, outdoor activities, relaxation activities, and social interactions; -The resident required special programming for cognitive and/or sensory deficit programming like sensory stimulation, reality orientation, validation, with one-on-one visits, and group; -Activities staff to assist the resident with bingo and other games. Review of the resident's One-to-One Activities Log for 07/16/24-07/31/24, showed the following: -07/20/24: length of visit: blank for minutes. Activity: sensory scent. Participant response: put lotion on the resident's hand he/she loved the smell. -07/25/24: length of visit: 10 minutes. Activity: discussion/conversation. Participant response: combed h

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	265407	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire Senior Living Moberly	700 East Urbandale Drive Moberly, MO 65270

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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. 38016 Based on observation, interview, and record review, the facility failed to provide adequate staffing to monitor residents, provide oversight, and to provide activities to the ten residents who resided on the memory care unit. The facility census was 64. Review of the Facility Assessment, updated 02/12/24, showed the following: -The facility was licensed for 120 total beds; 14 of these beds were located on the locked unit (dementia care); -The facility had an average daily census of 71 ranging from 65-72 residents at a time; -There was an average of 12 residents located on the locked dementia care unit; -Approach to Staffing: -Five certified nurse assistants (CNAs) on day shift 6:00 A.M.-2:00 P.M.; -Five CNAs on evening shift 2:00 P.M.-10:00 P.M.; -Three CNAs on night shift 10:00 P.M.-6:00 A.M. -Staffing plan for the memory care unit was 16 hours per resident day for days and for nights; -Assignments were determined on a continuing and daily level based upon the acuity/needs of the current residents in the facility. Review of the Resident Bed List Report, dated 09/15/24, showed the census on the locked dementia unit was ten residents. Review of the Daily Staffing Sheet, dated 09/15/24, showed the following: -Five CNAs on the day shift; -Five CNAs on the evening shift; -Three CNAs on the night shift. (One of the CNAs worked on the memory care unit on the day, evening and night shifts.) Observation on 09/15/24, at 5:05 P.M.-5:30 P.M., showed the following: -CNA K was the only staff on the memory care unit; (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Resident #21 wandered up and down the hall and in and out of rooms; -Resident #28 and Resident #50 were in the dining room with their supper trays in front of them on the table; -Resident #50's wheelchair wheels were locked and the arm rests were against the table; -Resident #17 sat in his/her room on the side of the bed eating his/her supper; -Resident #22 was in his/her room in bed with his/her eyes open; -Resident #12 sat in his/her room in a recliner eating his/her supper; -The three other residents on the locked unit were in the main dining room for the supper meal; -Between 5:05 P.M. and 5:30 P.M., CNA K went from the dining room, down to the end of the hall to Resident #12's room, cued Resident #21 where ever he/she was at the time, and assisted Resident #17 with his/her meal tray, then went back to check on the residents eating in the dining area; -CNA K left the residents unattended in the dining area when he/she had to leave the dining area to assist other residents and left Resident #21 wandering in and out of rooms without supervision. During an interview on 0915.24, at 5:10 P.M., CNA K said all the residents on the memory care unit, except for one resident, needed assistance with toileting. He/She had to leave all the residents unattended when he/she had to assist with toileting nine residents. Observations in the memory care unit on 09/16/24, between 10:40 A.M.-11:10 A.M., showed the following: -Certified Medication Technician (CMT) N was the only staff on the memory care unit and assisted residents in their rooms; -Resident #50 sat in his/her wheelchair with the arm rests against the dining room table with the wheels locked; -Resident #22 sat reclined in a high-back wheelchair in the dining room. The resident's head was down and his/her eyes were closed; -Resident #21 wandered in and out of residents' rooms, down the hallway and in and out of the dining room; -CMT N assisted residents in their rooms and went into the dining room one time at 10:54 A.M. During an interview on 09/16/24, at 10:51 A.M., CMT N said he/she watched the unit while CNA O gave Resident #12 a shower off of the unit. During an interview on 09/16/24, at 11:37 A.M., CNA O said the following: (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She was the only staff on the memory care unit and could not watch the residents all the time; -There were incontinent residents he/she had to toilet and other residents he/she had to check on often because they wandered or needed assistance; -There used to be two staff on the memory care unit unit, but the facility census was down so they decreased the staffing to one staff on the unit. It was overwhelming to keep up with all the residents and make sure they had what they needed; -There were no activities for the residents on the memory care unit because they decreased the staffing on the unit; -When there were two CNAs, one CNA would entertain the residents in the dining area with an activity while the other CNA would toilet, groom, and shower the other residents; -The activity staff did not have time to do activities for the residents on the dementia unit. During an interview on 09/16/24 at 4:40 P.M., CNA/CMT R (the staffing coordinator), said since the census was below 70 for the building, they were only allowed to have one staff on the memory care unit. The census for the memory care unit was usually 10 to 12 residents and didn't change much. The facility staffing was based on the census for the entire building. During an interview on 09/18/24 at 10:09 A.M., CNA W said the following: -He/She worked on the memory care unit full time until three weeks ago; -CNA O used to monitor the dining room and keep residents busy with painting or doing activities while he/she took residents to the bathroom, provided showers, and whatever needed to be done; -He/She was now part time because the facility had to cut staffing because the census was below 70; -Now there was no one to do any activities on the unit. The staff were very busy toileting the residents and trying to get showers completed; -All of the residents on the unit, except for one resident, were at risk for falling so staff were up and down the hall, to the dining room and constantly trying to monitor Resident #21. During an interview on 09/18/24, at 09:00 A.M., the Director of Nursing said the staffing on the dementia unit was decreased to one CNA a few weeks ago because of the budget. During an interview on 10/03/24, at 3:30 P.M., the Administrator said the following: -The staffing decreased a few weeks ago when the census fell ; -The staffing on the memory care unit decreased at that time when the census on the memory care unit fell to eight residents. (The census on the memory care unit during the recertification survey was 10); (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-She and department heads made the decision to decrease staffing; -Since some of the residents came to the main dining room for meals and activities, it made sense to decrease the staffing on the memory care unit; -She felt one staff could handle the ten residents on the unit. 42592

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38016 Based on interview and record review, the facility failed to ensure an approved indication for use of psychotropic medications for one resident (Resident #21), in a review of five residents sampled for unnecessary medications. Resident #21 had an order for risperidone (an antipsychotic medication) which is contraindicated for use in residents with dementia related psychosis. The resident's dosage of risperidone (an antipsychotic medication) was increased after the resident presented with one day of behaviors on 01/19/24 after the medication was decreased on 01/16/24. The resident's medical record did not contain documentation the facility assessed the root cause of the resident's behaviors or attempted non-pharmacological interventions to address the behaviors prior to increasing and adding medications to the resident's medication regimen. The facility census was 64. Review of Drugs.com on 9/18/24, showed the following: -Risperidone is an antipsychotic medicine that works by changing the effects of chemicals in the brain; -Risperidone is used to treat schizophrenia (a mental health disorder that affects a person's ability to think, feel, and behave clearly) in adults and children who are at least [AGE] years old; -Warnings included that risperidone is not approved for use in older adults with dementia-related psychosis; -In randomized placebo-controlled trials in elderly patients with dementia-related psychosis, cerebrovascular adverse events (strokes) occurred more frequently in patients treated with atypical antipsychotics than those receiving placebo; -Buspar is an anti-anxiety medicine that affects chemicals in the brain that may be unbalanced in people with anxiety; -Taking this medicine with other drugs that make you sleepy or slow your breathing can worsen these effects; -Medications that can interact with Buspar included Trazodone (an antidepressant medication) and other medications for anxiety, depression, or seizures. -Trazodone is an antidepressant used to treat major depressive disorder. Review of the facility policy Antipsychotic Medication Use, revised December 2016, showed the following: -Antipsychotic medications may be considered for residents with dementia but only after medical, physical, functional, psychological, emotional psychiatric, social and environmental causes of behavioral symptoms have been identified and addressed; (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Antipsychotic medications will be prescribed at the lowest possible dosage for the shortest period of time and are subject to gradual dose reduction and re-review; -Residents will only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective; -The attending physician and other staff will gather and document information to clarify a resident's behavior, mood, function, medical condition, specific symptoms, and risks to the resident and others; -The attending physician will identify, evaluate, and document, with input from other disciplines and consultants as needed, symptoms that may warrant the use of antipsychotic medications; -The attending physician and facility staff will identify acute psychiatric episodes, and will differentiate them from enduring psychiatric conditions. -Residents who are admitted from the community or transferred from a hospital and who are already receiving antipsychotic medications will be evaluated for the appropriateness and indications for use. The interdisciplinary team will: a. Complete PASARR screening (preadmission screening for mentally ill and intellectually disabled individuals), if appropriate; or b. Re-evaluate the use of the antipsychotic medication at the time of admission and/or within two weeks (at the initial MDS assessment) to consider whether or not the medication can be reduced, tapered, or discontinued; c. Based on assessing the resident's symptoms and overall situation, the physician will determine whether to continue, adjust, or stop existing antipsychotic medication; -Diagnosis of a specific condition for which antipsychotic medications are necessary to treat will be based on a comprehensive assessment of the resident. Antipsychotic medications shall generally be used only for the following conditions/diagnoses as documented in the record, consistent with the definition(s) in the Diagnostic and Statistical Manual of Mental Disorders (current or subsequent editions): a. Schizophrenia; b. Schizoaffective disorder; c. Schizophreniform disorder; d. Delusional disorder; e. Mood disorders (e.g. bipolar disorder, depression with psychotic features, and treatment refractory major depression); (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	f. Psychosis in the absence of dementia; g. Medical illnesses with psychotic symptoms and/or treatment-related psychosis or mania (e.g., high- dose steroids); h. Tourette's Disorder; i. Huntington Disease; J. Hiccups (not induced by other medications); or k. Nausea and vomiting associated with cancer or chemotherapy. -Diagnoses alone do not warrant the use of antipsychotic medication. In addition to the above criteria, antipsychotic medications will generally only be considered if the following conditions are also met: a. The behavioral symptoms present a danger to the resident or others; AND: (l) the symptoms are identified as being due to mania or psychosis (such as auditory, visual, or other hallucinations; delusions, paranoia or grandiosity); or (2) behavioral interventions have been attempted and included in the plan of care, except in an emergency (see below). -For enduring psychiatric conditions, antipsychotic medications will not be used unless behavioral symptoms are: a. Not due to a medical condition or problem (e.g., headache or joint pain, fluid or electrolyte imbalance, pneumonia, hypoxia, unrecognized hearing or visual impairment, medication side effect, or polypharmacy) that can be expected to improve or resolve as the underlying condition is treated or the offending medication(s) are discontinued; and b. Persistent or likely to reoccur without continued treatment; and c. Not sufficiently relieved by non-pharmacological interventions; and d. Not due to environmental stressors (e.g., alteration in the resident's customary location or daily routine, unfamiliar care provider, hunger or thirst, excessive noise for that individual, inadequate or inappropriate staff response, physical barriers) that can be addressed to improve the psychotic symptoms or maintain safety; and e. Not due to psychological stressors (e.g., loneliness, taunting, abuse), or anxiety or fear stemming from misunderstanding related to his or her cognitive impairment (e.g., the mistaken belief that this is not where he/she lives or inability to find his or her clothes or glasses) that can be expected to improve or resolve as the situation is addressed. -Antipsychotic medications will not be used if the only symptoms are one or more of the following: (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. Wandering; b. Poor self-care; c. Restlessness; d. Impaired memory; e. Mild anxiety; f. Insomnia; g. Inattention or indifference to surroundings; h. Sadness or crying alone that is not related to depression or other psychiatric disorders; i. Fidgeting; J. Nervousness; or k. Uncooperativeness; -All antipsychotic medications will be used within the dosage guidelines listed in F757, or clinical justification will be documented for dosages that exceed the listed guidelines for more than 48 hours. -The staff will observe, document, and report to the attending physician information regarding the effectiveness of any interventions, including antipsychotic medications. -Nursing staff shall monitor for and report any of the following side effects and adverse consequences of antipsychotic medications to the attending physician: a. General/anticholinergic: constipation, blurred vision, dry mouth, urinary retention, sedation; b. Cardiovascular: orthostatic hypotension, arrhythmias; c. Metabolic: increase in total cholesterol/triglycerides, unstable or poorly controlled blood sugar, weight gain; or d. Neurologic: Akathisia, dystonia, extrapyramidal effects, akinesia; or tardive dyskinesia, stroke or TIA. -The physician shall respond appropriately by changing or stopping problematic doses or medications, or clearly documenting (based on assessing the situation) why the benefits of the medication outweigh the risks or suspected or confirmed adverse consequences. 1. Review of Resident #21's annual Minimum Data Set (MDS), a federally required assessment completed by staff, dated 10/18/23, showed the following: (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Resident admitted to the facility on [DATE]; -Severe cognitive impairment; -Sometimes understands simple direct communication only; -Diagnosis of Alzheimer's disease, dementia, depression, and anxiety. -No wandering, behaviors, or rejection of care; -One non-injury fall since admission; -Receives antipsychotic and antidepressant medication. Review of the resident's Physician's Order Sheet, dated October 2023, showed the resident was admitted to the facility on risperidone 0.25 milligrams (mg) two times daily. Review of the resident's Physician Response to Pharmacist Recommendation, dated 01/16/24, showed the resident's dose of risperidone was decreased to once a day. Review of the resident's Physician's Order Sheet, dated October 2023, showed the resident was admitted to the facility on risperidone 0.25 milligrams (mg) two times daily. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Diagnosis added of unspecified psychosis; -No wandering, behaviors, or rejection of care; -Receives antipsychotic and antidepressant medication; -Antipsychotic medication used routinely. Review of the resident's nursing Progress Note, dated 01/19/24 at 3:22 A.M., showed the resident had an episode of physical aggression towards staff this evening. While trying to perform cares for the resident, he/she became very agitated, combative and was trying to hit staff. Another staff member was able to redirect the resident and assisted the resident to bed. No further behaviors noted. (Review of the resident's Care Plan showed it did not include any interventions for behaviors prior to 7/22/24.) Review of the resident's nursing Progress Note, dated 01/19/24 at 1:35 P.M., showed staff observed the resident hand in hand with another resident standing up in dining/common area on assigned unit. An investigation was completed. Interviews and statements were reviewed, and it was concluded that the resident may have been swatted/struck by a peer in his/her face after he/she grabbed onto the peer's shirt and would not let go. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's medical record showed no documentation of non-pharmacological interventions or a root analysis for the cause of the resident's behaviors on 1/19/24. Review of the resident's nursing Progress Note, dated 01/26/24, showed the resident was agitated with staff's assistance. Review of the resident's medical record showed no documentation of non-pharmacological interventions or a root analysis for the cause of the behaviors on 1/26/24. Review of the resident's medical record showed no other documentation of resident behaviors or rejection of care from 01/26/24 -02/07/24. Review of the resident's nursing Progress Note, dated 02/07/24, showed the Nurse Practitioner saw the resident and gave new orders to increase risperidone 0.25 mg to twice daily due to GDR. Review of the resident's Physician's Order Sheet, dated 02/07/24, showed risperidone 0.25 mg two times daily for unspecified psychosis. Review of the resident's quarterly MDS, dated [DATE], showed a new diagnosis of pseudobulbar affect (PBA) (a condition that's characterized by episodes of sudden uncontrollable and inappropriate laughing or crying) was added, and a new antianxiety medication was in use. Review of the resident's Physician Orders Sheet, dated 05/08/24, showed the following: -A new order for Remeron (an antidepressant medication) 15 mg tablet. Take one-half tablet by mouth every night at bedtime for major depressive disorder; -A new order for Buspar (an antianxiety medication) 5 mg three times a day for anxiety disorder. Review of the resident's medical record showed no documentation of increased anxiety or depression. Review of the resident's Physician Orders Sheet, dated 07/10/24, showed a new order for Trazodone (an antidepressant medication) 50 mg at bedtime for insomnia. Review of the resident's medical record showed no documentation of the resident having trouble sleeping. Review of the resident's Pharmacist Recommendations, dated 7/12/24, showed the following: -The resident has an order for risperidone 0.25 mg two times daily since February 2024; -Remeron 7.5 mg at bedtime, trazodone 50 mg at bed time, Buspar 5 mg three times a day, and depakote sprinkles (a seizure medication used off label for mood stabilization) 125 mg three times a day; -Please consider a gradual dose reduction for the resident's medications; -The review included hand written no change on the form. The form did not indicate who documented no change and did not have a physician's signature or signature of a staff member. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's Care Plan, last updated 07/22/24, showed the following: -The resident was on medications for anxiety, PBA, psychosis and to help with his/her appetite; -The resident was at risk for side effects of my medications; -Administer medications as ordered for psychosis, pseudobulbar affect, anxiety, insomnia, depression and to help with his/her appetite; -The resident is confused related to Alzheimer's disease and dementia; -He/She does not always understand what is going on around him/her; -The resident wanders about the unit and goes into other residents' rooms at times; -Provide the resident with safe wandering by supervising his/her activity and whereabouts, but not restricting his/her movements unless they are unsafe or unwanted by his/her peers; -Monitor the resident's behaviors and become familiar with his/her individual habits. (The care plan did not provide specific interventions for behaviors.) Review of the resident's Care Plan, updated 07/25/24, showed the resident was combative with a peer related to peer sitting in the recliner the resident preferred to sit in. Review of the resident's medical record showed no documentation of non-pharmacological interventions implemented or a root analysis for the cause of the behaviors/combativeness on 07/25/24. Review of the resident's Physician's Order Sheet, dated 08/01/24, showed a new order for depakote sprinkles 250 mg three times daily for unspecified psychosis. Review of the resident's Psychiatric Note, dated 8/15/24, showed the following: -Diagnosis include dementia without behavioral disturbance, anxiety, depression, insomnia, and PSA; -Remeron 15 mg tablet, take on-half tablet by mouth every night at bedtime; -Buspar 5 mg tablet, take one tablet by mouth twice a day; -Risperidone 0.25 mg tablet, take one tablet by mouth twice a day; -Trazodone 50 mg tablet, take on-half tablet by mouth every night at bedtime; -Depakote sprinkles 125 mg delayed release capsule, take two capsule by mouth three times a day. -Unable to assess for any hallucinations or delusions; -Staff reported the resident can be combative with staff during cares on the last visit. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(The psychiatric nurse practitioner did not include a diagnosis of psychosis or symptoms of psychosis in the progress note.) Review of the resident's medical record showed no documentation the facility provided the resident's responsible party with education or obtained consent for the use of antipsychotic medication, no documentation for monitoring for side effects, and no documentation of any other behaviors (other than wandering) than what behaviors are listed above. During an interview on 09/16/24, at 1:16 P.M., the resident's responsible party said the facility staff forgets to call him/her with order changes or issues. He/She was not made aware of medication changes for behaviors. The facility had not contacted him/her about the resident having behaviors. During an interview on 09/18/24, at 9:00 A.M. and 11:20 A.M., the Director of Nursing said the resident was on risperidone for unspecified psychosis, not his/her dementia. She expected staff to follow the Psychotropic Drug use policy.

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	265407	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire Senior Living Moberly	700 East Urbandale Drive Moberly, MO 65270

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 34536 Based on observation, interview, and record review, the facility failed to label, date and cover food items, failed to properly wear hair restraints, failed to utilize proper handwashing and glove use while handling ready to eat food items, failed to maintain the walk-in cooler fan shrouds to be free of a buildup of debris, and failed to ensure the ice machine had an appropriate air gap. The facility census was 64. Review of the facility policy, Labeling and Dating Foods (Date Marking), dated 2020, showed the following: -All foods stored will be properly labeled according to the following guidelines; -Date marking for refrigerated storage food items: Once opened, all ready to eat, potentially hazardous food will be re-dated with a use by date according to current safe food storage guidelines or by the manufacturer's expiration date; -Prepared food or opened food items should be discarded when: The food item does not have a specific manufacturer expiration date and has been refrigerated for 7 days. The food item is leftover for more than 72 hours. The food item is older than the expiration date. 1. Observation on 9/15/24 at 2:42 P.M. showed the following items in the refrigerator: -A container of macaroni salad was not dated; -A container of pepper gravy, dated 9/15/24, had a lid that was open and unsealed; -A container of jelly, dated 9/6/24, had a lid that was open and unsealed; -A container of green beans, dated 9/14/24, and had a lid that was open and unsealed; Observation on 09/16/24 at 9:16 A.M. showed the following items stored inside the walk-in cooler: -A large container of grape jelly, dated September 6, had a lid that was not sealed; -A Ziplock bag with four blocks of sliced cheese, dated 9/16/24, was open to air and not sealed. Observation on 9/16/24 at 9:22 A.M. showed the following food items were stored on the metal preparation counter behind the steam table: -A round plastic container of potato chips was not dated; -A large plastic container of cheese puffs was not dated. 2. Review of the facility policy, Hair Restraints, dated 2020 showed the following: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Dining services staff shall wear hair restraints when in food production areas, dishwashing areas or when serving food; -Hair restraints, hats, and/or beard guards shall be used to prevent hair from contacting exposed food. Facial hair is discouraged. Any facial hair that is longer than the eyebrow shall require coverage with a beard guard in the production and dishwashing areas. Observation on 9/16/24 at 9:29 A.M. showed Dietary Staff I placed dirty dishes in a rack and pushed the rack into the dish machine. He/She had facial hair and did not wear a beard restraint. Observation on 9/16/24 at 11:40 A.M. Dietary Staff J wore a hair restraint, but his/her hair restraint did not cover all of his/her hair and approximately 3-inches of hair remained outside of the hair restraint. His/Her facial hair was not covered by a beard guard. He/She prepared turkey and cheese sandwiches at the preparation counter. He/She finished the sandwiches and began cooking a frozen hamburger in a skillet. 3. Review of the facility policy, Proper Hand Washing and Glove Use, dated 2020, showed the following: -All employees will use proper hand washing procedures and glove usage in accordance with State and Federal sanitation guidelines; -All employees will wash hands before and after handling foods, after touching any part of the uniform, face, or hair, and before and after working with an individual resident; -Gloves are to be used whenever direct food contact is required; -Hands are washed before donning gloves and after removing gloves; -Gloves are changed any time hand washing would be required. This includes when leaving the kitchen for a break, or to go to another location in the building; after handling potentially hazardous raw food; or if the gloves become contaminated by touching the face, hair, uniform or other non-food contact surface, such as door handles and equipment; -Staff should be reminded that gloves become contaminated just as hands do, and should be changed often. When in doubt, remove gloves and wash hands again; -When gloves must be changed, they are removed, hand washing procedure is followed, and anew pair of gloves is applied. Gloves are never placed on dirty hands; the procedure is always wash, glove, removed, re-wash and re-glove. Observation on 9/16/245 at 12:06 P.M. showed Dietary Aide J did not wash his/her hands and donned a pair of gloves. He/She touched the walk-in cooler door, did not remove his/her gloves, then touched two slices of bread, touched a slice of cheese and slices of turkey and prepared a sandwich for a resident. He/She did not wash hands or change gloves during this process. He/She wiped his/her mouth with his/her arm and gloved hand, did not change his/her gloves, and placed the sandwich on a resident's plate with his/her gloved hand. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 9/17/24 at 8:57 A.M. Dietary Aide I placed and arranged dirty silverware on a plastic rack. He/She held and used the sprayer to rinse the dirty silverware. He/She used the handle on the dishmachine to open the dishmachine door. Without washing his/her hands after handling the dirty silverware, he/she reached inside the dishmachine and grabbed a clean steam table pan with his/her dirty hands. 4. Observation on 9/16/24 at 9:16 A.M. showed the walk-in cooler fan shrouds had a heavy buildup of fuzzy debris and rust. 5. Observation on 9/16/24 at 10:43 A.M., of the facility's ice machine, showed an approximate 4-foot long section of 1-inch diameter pipe extended from the ice machine drain and entered into a 3-inch flanged drain pipe. The 1-inch pipe was approximately 2-inches below the flood rim level of the flanged drain pipe and did not contain an air gap. During an interview on 9/16/24 at 10:45 A.M., the Maintenance Director said he did not know an air gap was required at the ice machine drain. 6. During an interview on 9/17/24 at 9:32 A.M., the Dietary Manager said the following: -Staff should label, date and cover all food items; -Some container lids did not fit very well or correctly and probably need to be thrown away; -She was unsure who was responsible for cleaning the walk-in cooler fan shrouds; -Staff should wear hair restraints in the kitchen at all times. Staff with facial hair should wear beard guards. All hair should be contained inside the hair restraint. The person washing dishes should also wear a hair restraint; -Staff should wash their hands when they enter the kitchen and then should wear gloves at their work station. If staff left their station or changed tasks, they should remove their gloves and wash their hands. -Staff should handle ready-to-eat food with clean gloves, clean hands or utensils; -Staff should not touch their hair or face with gloved hands. If so, they should remove gloves and wash hands.

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F 0847 Level of Harm - Potential for minimal harm Residents Affected - Many	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. 42592 Based on interview and record review, the facility failed to ensure all required components of an arbitration agreement were part of the facility policy. This failure affected all of the residents in the facility, as all residents had a signed arbitration agreement. The facility census was 64. Review of the undated facility Admission Agreement Packet showed the following: -Alternative Dispute Resolution Addendum: This Alternative Dispute Resolution Addendum is attached to and made a part of the Admission Agreement between the facility and the resident. All claims, disputes, and controversies arising out of or in any manner relating, directly or indirectly, to the resident's care or stay at the facility (in each case, a dispute) shall be subject to certain alternative dispute resolution procedures that must be exhausted prior to pursuing any other remedy that may be available. Those required alternative dispute resolution procedures are: (a) mandatory non-binding mediations; and (b) mandatory nonbinding appealable arbitration; -Each party agrees that compliance with the requirements of this addendum shall be a condition precedent to its right to assert any claims with respect to a dispute in any other forum; -Mandatory Non-Binding Mediation: If there is a dispute, the party claiming the existence of a dispute must make written demand for mediation prior to instituting a lawsuit, action or arbitration proceeding. Mediation of any dispute must be attempted in good faith; -The mediation shall be conducted in the county where the facility is located, unless another location is mutually agreed upon by the parties. The cost and expensed of mediation, with the exception of the costs and expenses relating to the investigation, representation and case presentation on behalf of the resident, shall be borne by the facility; -The mediator shall be chosen by joint agreement of the resident and the facility. In the event an agreement cannot be reached with respect to a mediator, either party may request that Judicial Arbitration and Mediation Services (JAMS), Inc. or its successor appoint a mediator. Selection of the mediator by JAMS shall be binding on the resident and the facility; -Mandatory Non-Binding Appealable Arbitration: Should mandatory non-binding mediation of the dispute be unsuccessful, it is agreed that the dispute shall be submitted to non-binding appealable arbitration in accordance with the Health Care Clams Settlement Procedures, as promulgated, amended and administered by the American Arbitration Association; -All arbitration hearings conducted hereunder shall take place in the county where the facility is located. The hearing before the arbitrator(s) of the matter to be arbitrated shall be at the time and place within said county as is selected by the arbitrator(s); -The decision of the arbitrator(s) will respect to a dispute shall be non-binding and appealable to a court having jurisdiction; (continued on next page)

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F 0847 Level of Harm - Potential for minimal harm Residents Affected - Many	-This contract contains an arbitration provision. This may be enforced by the parties. Review of the facility provided Admission Agreement showed the Arbitration Agreement did not include: -The resident or his/her representative was not required to enter into the agreement as a condition of admission to the facility or as a requirement to continue to receive care; -Did not include language which made clear the resident or representative could communicate with federal, state, or local officials; -The resident or his/her representative had the right to rescind the agreement within 30 calendar days of signing the agreement. During an interview on 09/18/24, at 5:40 P.M., the Social Services Director said the following: -She was responsible for obtaining initials and signatures on the arbitration agreement; -She asked the resident/resident representative if they understood what they were signing before they signed or initialed the agreement; -It was the resident/resident representative's option to sign the agreement or not sign the agreement; -The signed arbitration agreement was not a condition of admission to the facility; -She was not aware of what specific language was required on the arbitration agreement, as the agreement was produced by corporate; -She was not aware that the resident/resident representative had 30 days to rescind the arbitration agreement. During an interview on 09/18/24, at 5:35 P.M., the administrator said the following: -Social Services was responsible for obtaining the arbitration agreement; -Every resident in the facility had a signed arbitration agreement; -She was unaware of what specific components needed to be listed on the arbitration agreement prior to 09/18/24.