

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265450	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/09/2025
NAME OF PROVIDER OR SUPPLIER Aspire Senior Living Poplar Bluff		STREET ADDRESS, CITY, STATE, ZIP CODE 3001 May Street Poplar Bluff, MO 63901	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to follow physician's orders for one resident (Resident #1) out of five sampled residents by not administering the resident his/her medications in a timely manner. The facility census was 55. The administration was notified on 09/09/25 of the Past Non-Compliance which occurred on 08/17/25. On 08/31/25, upon notification, the facility administration started an investigation and completed a medication error report. In-serviced staff on Medication Administration Compliance. The non-compliance was corrected on 09/02/25, as the facility in-serviced the nursing staff responsible for medication administration on the facility's policy and procedures for Medication Administration Compliance. The facility policy titled, Physician/Practitioner Orders, undated, showed:- For all physician/practitioner orders received via telephone, the nurse will:a. Document the order notating the time, date, name and title of the person providing the order, and the signature and title of the person receiving the order;b. Follow facility procedures for verbal or telephone orders including, noting the order, submitting to pharmacy and transcribing to medication or treatment administration record.The facility policy titled, Medication Administration, undated, showed:- Review Medication Administration Record (MAR) to identify medications to be administered;- If any discrepancies noted, report to nurse manager. 1. Review of Resident #1's medical record showed:- Date of admission [DATE];- Diagnoses of dementia (a progressive mental deterioration) disease, schizoaffective (a condition characterized by abnormal thought processes and deregulated emotions) disorder, anxiety (worry and fear about everyday situations), depression, and persistent mood disorder (a chronic form of depression characterized by persistent low mood and other symptoms that last for at least two years).Review of the resident's September 2025 Physician Order Sheet (POS) showed:- An order for Invega Sustenna (an antipsychotic (a medication that alters thoughts and perceptions) medication) intramuscular (IM - an injection into the muscle) suspension 78 milligram (mg)/0.5 milliliter (ml) starting and ending on the 17th of every month for bipolar (a mental health condition that causes extreme mood swings), dated 08/01/25, and discontinued on 08/31/25;- An order for Invega Sustenna 78mg/0.5ml IM one time a day starting on the 1st of every month for bipolar, dated 08/31/25.Review of the resident's August 2025 Treatment Administration Record (TAR) showed:- Documentation to see the resident's progress note dated 08/17/25. Review of the resident's Progress Notes, dated 08/17/25, showed:- No documentation of the administration of the Invega injection or the reporting to the charge nurse of the medication not being administered as ordered. During an interview on 09/09/25 at 11:00 A.M., Licensed Practical Nurse (LPN) A said the Invega order had been changed due to a recent gradual dose reduction on 08/01/25. When the new order was put into the medical record, the Invega injection was populated on the Certified Medication Technician (CMT) MAR. When the injection populated on the CMT MAR, the CMT documented not given on the resident's MAR and did not report the medication wasn't given to the charge nurse. A CMT would not administer an Invega injection. The CMT should have notified the charge nurse the medication wasn't given so the charge nurse could administer it and document on it. During an interview on 09/09/25 at 11:03 A.M., LPN B said he/she was the charge nurse on 08/17/25, and the CMT never reported the medication was not given. During an interview on 09/09/25 at 11:47 A.M., the Director of Nursing (DON) said there was only one resident on Invega. On 08/01/25, the order was put into the medical record, and was due on 08/17/25. When a new order was put in the medical record, there were choices as to where it populated on a CMT MAR, CMT TAR, or the Licensed MAR. The medication populated on the CMT MAR. When the medication came due, the CMT did not pass onto the nurse that the medication was not given. She was not aware the Invega wasn't given until 08/31/25, when the resident's family called the facility regarding the injection. The facility worked with the corporate pharmacy to get the medication promptly. The psychiatric provider was notified immediately and gave an order to administer the medication on 09/01/25. During an interview on 09/09/25 at 12: 30 P.M., the Administrator said she expects staff to follow physician orders. Complaint #2609996</p>		