

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  01/09/2025
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 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p>45693</p> <p>Based on observation, interview, and record review, the facility failed to assess the use of a merry walker (an enclosed framed wheeled walker with a seat) to determine if it was a restraint, and failed to document an ongoing re-evaluation for the use of the merry walker for one resident (Resident #12) out of one sampled resident with a restraint. The facility census was 47.</p> <p>Review of the facility's policy titled, Use of Restraints, undated, showed:</p> <ul style="list-style-type: none"> <li>- Purpose is to 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;</li> <li>- The resident's record includes ongoing re-evaluation for the need for a restraint and is effective in treating the medical symptom;</li> <li>- 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.</li> </ul> <p>The facility did not provide a policy regarding merry walkers.</p> <p>1 Review of Resident #12's April 2024 Physician's Order Sheet (POS), showed:</p> <ul style="list-style-type: none"> <li>- Diagnoses of intellectual disability (a chronic condition that affects a person's ability to learn and function in daily life), mood disorder (a mental health problem that primarily affects a person's emotional state), restlessness and agitation, anxiety (persistent worry and fear about everyday situations), conduct disorder (a mental health condition that involves a pattern of aggressive and antisocial behaviors), and aphasia (loss of ability to understand or express speech caused by brain damage);</li> <li>- Requires merry walker due to unsteady gait and inability to understand that he/she is unable to ambulate independently. Maintain 100 pounds to the merry walker as ordered, dated 11/26/24, with the original order date of 12/31/19.</li> </ul> <p>Review of the resident's quarterly Minimum Data Sets (MDS - a federally mandated assessment instrument completed by the facility staff), dated 07/26/24 and 10/25/24, showed:</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:  Facility ID: 265450	If continuation sheet Page 1 of 28

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NAME OF PROVIDER OR SUPPLIER  Aspire Senior Living Poplar Bluff		STREET ADDRESS, CITY, STATE, ZIP CODE  3001 May Street Poplar Bluff, MO 63901	
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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> <li>- Severe cognitive impairment;</li> <li>- Impairment on both sides of the upper and lower extremities;</li> <li>- Dependent with full assist for sit to stand and transfers;</li> <li>- No restraint use.</li> </ul> <p>Review of the resident's medical record showed:</p> <ul style="list-style-type: none"> <li>- No assessment for the merry walker to determine if used as a restraint for 01/01/24 - 12/31/24, and 01/01/25-01/09/25;</li> <li>- No documentation of alternatives tried prior to the merry walker use;</li> <li>- No documentation of the least restrictive use for the merry walker;</li> <li>- No documentation of ongoing re-evaluations for the use of the merry walker tray;</li> <li>- No documentation of consent for the restraint use.</li> </ul> <p>Review of the resident's Physical Therapy Evaluation Summary, dated 05/11/22, showed:</p> <ul style="list-style-type: none"> <li>- Resident referred to physical therapy due to a merry walker re-assessment needed to continue the use in the facility and to determine the resident was still safe;</li> <li>- Resident was a fall risk;</li> <li>- Resident used the merry walker for all ambulation tasks and was independent throughout the facility;</li> <li>- Resident wanted to walk, had appropriate hand placement, appropriate sit to stand technique, was able to maneuver around objects, and didn't ambulate at a fast pace;</li> <li>- Resident continued to independently perform sit to stand transfers and ambulation tasks with the merry walker. Resident was able to move around objects. Resident was able to maintain proper position and balance in sitting/standing when using the merry walker. The device continued to be very appropriate and safe for the resident at this time. The merry walker allowed for the highest level of functioning without restrictions. This device was the correct size and weight for the resident.</li> </ul> <p>Review of the resident's care plan, revised on 10/27/24, showed:</p> <ul style="list-style-type: none"> <li>- Resident was a fall risk;</li> <li>- Resident had behavioral symptoms and would use the merry walker to bump up against other residents;</li> </ul> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- Resident had physical restraints and used a merry walker restraint when out of bed for increased mobility and independence. It was used due to an unsteady gait and inability to understand the resident couldn't ambulate independently due to a medical diagnosis of mental retardation (a condition that affects a person's ability to think, learn, and adapt to their environment.). The merry walker enabled the resident to safely stand and walk short distances and didn't have a restraining effect. The resident was not able to use a traditional wheelchair or geri chair (supportive recliners and medical recliners provide more substantial support and comfort than conventional wheelchairs) due to constantly attempting to get up and down from it risking injury. Encourage participation of therapy in assessing, re-assessing, and determining the least restrictive restraint to use. Maintain 100 pound weights to the merry walker.</p> <p>Observations of the resident showed:</p> <ul style="list-style-type: none"> <li>- On 01/07/25 at 9:20 A.M., and 1:30 P.M., and on 01/08/25 at 1:30 P.M., the resident sat in the merry walker in the tv room;</li> <li>- On 01/07/25 at 11:45 A.M., the resident sat in the merry walker and pushed by staff into the dining room;</li> <li>- On 01/08/25 at 8:00 A.M., and on 01/09/25 at 7:50 A.M., the resident sat in the merry walker in the dining room and assisted to eat by staff;</li> <li>- On 01/08/25 at 10:30 A.M., the resident sat in the merry walker in the tv room and ran it into another resident in a wheelchair;</li> <li>- On 01/08/25 at 10:45 A.M., the resident sat in the merry walker in the tv room and ran it into an empty couch numerous times;</li> <li>- On 01/08/25 at 11:55 A.M., the resident sat in the merry walker in the dining room and ran into the piano numerous times;</li> <li>- On 01/08/25 at 2:48 P.M., Certified Nursing Assistant (CNA) B unlatched the closure of the merry walker and transferred the resident from the merry walker to the bed.</li> </ul> <p>During a telephone interview on 01/08/25 at 4:30 P.M., Certified Occupational Therapy Assistant (COTA) D said therapy had completed an evaluation a few years back on the resident for the merry walker. There had not been a recent one done that he/she was aware of. The resident had a history of falls and the merry walker kept that from happening. The resident also stood and walked on his/her tip toes.</p> <p>During an interview on 01/09/25 at 1:30 P.M., the Director of Nursing (DON) said a merry walker should be assessed quarterly as a restraint device to ensure it was still appropriate for the resident.</p> <p>During an interview on 01/09/25 at 2:00 P.M., the Administrator said she would expect the resident to have quarterly assessments and documentation regarding the merry walker and restraint assessment. The documentation should include all the required information to show the merry walker was the correct device for the resident.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37575</b></p> <p>Based on observation, interview, and record review, the facility failed to provide scheduled showers for three residents (Residents #5, #24 and #32) out of four sampled residents for activities of daily living (ADLs). The facility census was 47.</p> <p>Review of the facility's policy titled, Necessary Care and Services, dated 01/20/24, showed:</p> <ul style="list-style-type: none"> <li>- The facility will ensure that a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, personal and oral hygiene.</li> </ul> <p>1. Review of Resident #5's quarterly Minimum Data Set (MDS - a federally mandated assessment completed by the facility), dated 10/08/24, showed:</p> <ul style="list-style-type: none"> <li>- Dependent for personal hygiene and showers.</li> </ul> <p>Review of the resident's care plan, revised 10/13/24, showed:</p> <ul style="list-style-type: none"> <li>- Did not address showers/bathing frequency;</li> <li>- Did not address assistance required for showers/bathing.</li> </ul> <p>Review of the shower schedule, dated 12/01/24 - 01/07/25, showed the resident's showers were scheduled for Monday and Thursday night shifts.</p> <p>Review of the resident's shower sheets, dated 12/01/24 - 01/07/25, showed:</p> <ul style="list-style-type: none"> <li>- No documentation of completion for scheduled showers on 12/02/24, 12/05/24, 12/12/24, 12/19/24, 12/23/24, 12/26/24, 12/30/24, 01/02/25, and 01/06/25;</li> <li>- A bed bath documented with hair not washed and face not shaved on 12/09/24;</li> <li>- Nine opportunities missed out of 11 opportunities for scheduled showers;</li> <li>- 10 opportunities missed out of 11 opportunities for scheduled facial shaving and hair washing;</li> <li>- The facility failed to provide showers two times per week as scheduled.</li> </ul> <p>Observation of the resident on 01/07/25 at 10:20 A.M., and on 01/08/25 at 9:04 A.M., showed:</p> <ul style="list-style-type: none"> <li>- On 01/07/25 at 10:20 A.M., the resident with unkempt, unshaven facial hair approximately 1/4 inch long, with dry flakes of skin in/on his/her hair, face, and facial hair;</li> <li>- The resident with dry skin flakes on his/her shirt.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 01/07/25 at 10:20 A.M., Resident #5 said he/she did not like the facial hair and would like to be shaved.</p> <p>During an interview on 01/08/25 at 9:04 A.M., Resident #5 said he/she would like a shower and shave today and if it would happen.</p> <p>During an interview on 01/08/25 at 9:00 A.M., the Administrator said Resident #5 should be showered and shaved as scheduled and as needed/wanted.</p> <p>2. Review of Resident #24's quarterly MDS, dated [DATE], showed:</p> <ul style="list-style-type: none"> <li>- Dependent for personal hygiene and showers.</li> </ul> <p>Review of the resident's care plan, revised 11/08/24, showed:</p> <ul style="list-style-type: none"> <li>- Did not address showers/bathing frequency;</li> <li>- Did not address assistance required for showers/bathing.</li> </ul> <p>Review of the resident's shower schedule, dated 12/01/24 - 01/07/25, showed the resident's showers were scheduled for Tuesday and Friday.</p> <p>Review of the resident's shower sheets, dated 12/01/24 - 01/06/25, showed:</p> <ul style="list-style-type: none"> <li>- No documentation of completion for scheduled showers on 12/03/24, 12/17/24, 12/27/24, 12/31/24, 01/03/25 and 01/06/24;</li> <li>- Six opportunities missed out of 11 opportunities for scheduled showers;</li> <li>- The facility failed to provide showers two times per week as scheduled.</li> </ul> <p>3. Review of Resident #32's significant change MDS, dated [DATE], showed:</p> <ul style="list-style-type: none"> <li>- Substantial/maximal assist for personal hygiene;</li> <li>- Dependent for showers.</li> </ul> <p>Review of the resident's care plan, revised 08/21/24, showed:</p> <ul style="list-style-type: none"> <li>- Did not address showers/bathing frequency;</li> <li>- Did not address assistance required for showers/bathing.</li> </ul> <p>Review of the resident's shower schedule, dated 12/01/24 - 01/06/25, showed the resident's showers were scheduled for Mondays and Thursdays.</p> <p>Review of the resident's shower sheets, dated 12/01/24 - 01/06/25, showed:</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- No documentation for completion of scheduled showers on 12/02/24, 12/12/24, 12/16/24, 12/26/24, 12/30/24 and 01/06/24;</p> <p>- Six opportunities missed out of 11 opportunities for scheduled showers;</p> <p>- The facility failed to provide showers two times per week as scheduled.</p> <p>During an interview on 01/08/24 at 1:41 P.M., Resident #32 said showers were not being given two times a week as scheduled. It was more like once a week.</p> <p>During an interview on 01/08/25 at 3:25 P.M., the Administrator said she was aware the facility was having issues with showers being completed and they were trying to come up with a remedy for that. She would hope the residents were at least getting one shower a week if not the two that were scheduled.</p> <p>During an interview on 01/09/25 at 09:18 A.M., Certified Nursing Assistant (CNA) B said the showers were probably not always being completed two times a week.</p> <p>During an interview on 01/09/25 at 11:34 A.M., the Director of Nursing said showers were an issue and they were working to try and find a solution to fix it.</p> <p>45693</p> <p>47445</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45693</p> <p>Based on interview and record review, the facility failed to ensure staff utilized safe transfer techniques for one resident (Resident #29) when staff failed to transfer the resident with assist of a gait belt (a device used to aid in the safe movement of a person from one place to another) of one sampled resident. The facility census was 47.</p> <p>Review of the facility's policy titled, Policy on the Use of Gait Belts in Long-Term Care Facilities, dated 01/30/24, showed:</p> <ul style="list-style-type: none"> <li>- Purpose is to ensure the safe and effective use of gait belts in assisting residents with mobility and transfers, thereby reducing the risk of injury to both residents and staff in long-term care facilities;</li> <li>- Gait belts must be used when assisting residents who require help with walking, standing, or transferring;</li> <li>- Gait belts should be used for residents with unsteady gait, those at risk of falls, or those who need support during mobility activities;</li> <li>- Residents who refuse the use of a gait belt must be accommodated with alternative methods of assistance.</li> </ul> <p>1. Review of Resident #29's medical record showed:</p> <ul style="list-style-type: none"> <li>- An admitted [DATE];</li> <li>- Diagnoses of spinal stenosis (a narrowing of the spinal canal that occurs when the spaces in the spine narrow, putting pressure on the spinal cord and nerve roots), moderate protein-calorie malnutrition, anxiety (persistent worry and fear about everyday situations), muscle weakness, contracture (damage to muscle tissue or joint that prevents normal mobility) of the left hand, and a history of wedge compression fracture (a type of spinal compression fracture that occurs when the front of a vertebra collapses, giving the bone a wedge shape) of the fourth lumbar (refers to the lower back, or the five vertebrae (L1-L5) in that region of the spine) vertebra.</li> </ul> <p>Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument required to be completed by the facility staff, dated 10/09/24, showed:</p> <ul style="list-style-type: none"> <li>- Moderately cognitively impaired;</li> <li>- Total dependence of staff for bed mobility, dressing, personal hygiene, and bathing;</li> <li>- Total dependence of staff for transfers and toilet use;</li> <li>- Always incontinent of bowel and bladder.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the resident's Care Plan, dated 10/13/24, showed:</p> <ul style="list-style-type: none"> <li>- Resident experienced severe pain in the neck, left arm and right hip;</li> <li>- Resident required activities of daily living (ADL) assistance regarding bowel irregularity;</li> <li>- Resident at risk of pressure ulcer/injury due to need of assistance with bed mobility;</li> <li>- The resident's transfer and mobility needs were not addressed.</li> </ul> <p>Observation on 01/08/25 at 3:00 P.M., of the resident's transfer from the wheelchair to the bed showed:</p> <ul style="list-style-type: none"> <li>- Certified Nursing Assistant (CNA) B attempted to place gait on the resident but the resident expressed significant pain;</li> <li>- CNA B said he/she was going to do what he/she normally did;</li> <li>- CNA B put one of his/her legs between the resident's legs, one of his/her arm's under the resident's right arm, and one of his/her arm's around the resident's left upper arm/shoulder;</li> <li>- CNA B lifted the resident from the wheelchair and transferred him/her to the bed;</li> <li>- The resident's right foot made partial contact with the floor, the left foot didn't make contact with the floor for half of the transfer, and the resident did not bear any weight during the transfer.</li> </ul> <p>During an interview on 01/08/25 at 3:10 P.M., CNA B said the resident's left arm was contracted and caused so much pain. The way CNA B transferred the resident was the only way to do it without causing extreme pain.</p> <p>During an interview on 01/08/25 at 3:30 P.M., Certified Occupational Therapy Assistant (COTA) E said if a gait belt couldn't be used on a resident, then they should be transferred by a Hoyer (a mechanical device used to move or transfer a person) lift. A gait belt should be used in all physical transfers. Residents should not be lifted under the arms as it could cause damage to the shoulder.</p> <p>During an interview on 01/09/25 at 2:30 P.M., the Director of Nursing (DON) said staff should always use a gait belt during transfers. If a gait belt couldn't be used, then they should use a hoyer lift.</p> <p>During an interview on 01/09/25 at 2:45 P.M., the Administrator said staff should use a gait belt during all transfers. If a gait belt couldn't be used due to pain or unable to bear weight, then a Hoyer lift should be used instead.</p>

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>45693</p> <p>Based on observation, interview, and record review, the facility failed to ensure one resident (Resident #12) out of five sampled residents who were incontinent of bowel and bladder, received appropriate treatment and services after an incontinent episode. Resident #12 was left without personal care for over six hours, resulting in the resident's brief soaked with dark urine and a strong urine odor. The census was 47.</p> <p>Review of the facility's policy titled, Necessary Care and Services, dated, 01/20/24, showed:</p> <ul style="list-style-type: none"> <li>- The facility will ensure that a resident who is unable to carry out activities of daily living (ADLs) receives the necessary services to maintain good nutrition, grooming, personal and oral hygiene.</li> </ul> <p>1. Review of Resident #12's quarterly Minimum Data Sets (MDS - a federally mandated assessment instrument completed by the facility staff), dated 07/26/24 and 10/25/24, showed:</p> <ul style="list-style-type: none"> <li>- Severe cognitive impairment;</li> <li>- Impairment on both sides of the upper and lower extremities;</li> <li>- Dependent, full assist for sit to stand and transfers;</li> <li>- Totally dependent for personal hygiene;</li> <li>- Totally incontinent of bowel and bladder.</li> </ul> <p>Review of the resident's care plan, revised 10/27/24, showed:</p> <ul style="list-style-type: none"> <li>- Resident required extensive assist with ADLs;</li> <li>- Incontinent care was not addressed.</li> </ul> <p>Review of the resident's medical record showed:</p> <ul style="list-style-type: none"> <li>- Diagnoses of intellectual disability (a chronic condition that affects a person's ability to learn and function in daily life), mood disorder (a mental health problem that primarily affects a person's emotional state), restlessness and agitation, anxiety (persistent worry and fear about everyday situations), conduct disorder (a mental health condition that involves a pattern of aggressive and antisocial behaviors), and aphasia (loss of ability to understand or express speech caused by brain damage);</li> </ul> <p>Review of the facility assignment sheet for 01/08/25 day shift showed:</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- Certified Nursing Assistant (CNA) B was the only assigned staff for the hall where Resident #12 resided.</p> <p>Observations of the resident on 01/08/25 showed:</p> <ul style="list-style-type: none"> <li>- At 8:00 A.M., the resident sat in the merry walker in the dining room and assisted to eat by staff;</li> <li>- At 10:30 A.M., the resident sat in the merry walker in the tv room and ran it into another resident in a wheelchair;</li> <li>- On 01/08/25 at 10:45 A.M., the resident sat in the merry walker in the tv room and ran it into an empty couch numerous times;</li> <li>- On 01/08/25 at 11:55 A.M., the resident sat in the merry walker in the dining room and ran into the piano numerous times;</li> <li>- On 01/08/25 at 1:30 P.M., the resident sat in the merry walker in the tv room;</li> <li>- On 01/08/25 at 2:48 P.M., CNA B pushed the resident in the merry walker to his/her room. CNA B transferred the resident from the merry walker to the bed. CNA B performed incontinent care. The resident's brief was soaked with dark urine and a strong urine odor.</li> </ul> <p>During an interview on 01/08/25 at 3:00 P.M., CNA B said the resident got up in the morning around 6:45 A.M., went to the dining room for breakfast, to the tv room, to the dining room for lunch, and then went to bed afterwards. The resident was put to bed today at 2:48 P.M. The resident was changed then when he/she was put to bed. The resident was checked for incontinence before getting up for supper and again at bedtime. The resident really should be checked for incontinence more often between breakfast and after lunch.</p> <p>During an interview on 01/08/25 at 4:35 P.M. the Administrator said all residents, including Resident #12, should be checked every two hours or at least once in between meals during the day for incontinence. Resident #12 should not have gone eight hours between being checked for incontinence and changed.</p> <p>During an interview on 01/09/25 at 2:00 P.M., the Director of Nursing (DON) said residents should be checked every two hours if they were incontinent and changed if they were soiled.</p>		

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NAME OF PROVIDER OR SUPPLIER  Aspire Senior Living Poplar Bluff		STREET ADDRESS, CITY, STATE, ZIP CODE  3001 May Street Poplar Bluff, MO 63901	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45693</p> <p>Based on observation, interview and record review, the facility failed to follow standards of practice when licensed staff didn't assess one resident's (Resident #12) gastrostomy tube (G-tube) (a small tube that's surgically inserted into the stomach through the abdomen) out of one sampled resident upon readmission to the facility from the emergency room (ER) when the G-tube was replaced after the resident pulled it out at the facility. This resulted in the facility holding the resident's feedings without a physician order for 11 days. The facility also failed to follow physician orders in obtaining weekly weights. The facility census was 47.</p> <p>Review of the facility's policy titled, Enteral Nutrition, dated 01/20/24, showed:</p> <ul style="list-style-type: none"> <li>- Responsibility of licensed nurse;</li> <li>- Assessment guidelines include; condition of mouth and gums, consistency of feces, condition of skin around feeding tube, weight, nutritional status, hydration, ability to chew and swallow, obstruction of esophagus;</li> <li>- Documentation guidelines: reason feeding was held if applicable, physician notification as necessary.</li> </ul> <p>1. Review of Resident #12's Physician's Order Sheet (POS), dated December 2024, showed:</p> <ul style="list-style-type: none"> <li>- An order for enteral (any method of feeding that uses the gastrointestinal tract to deliver nutrition) feed every day and night shift, start date 12/02/24, hold dates 12/13/24 - 12/18/24;</li> <li>- An order to check the G-tube placement before initiation of formula, medication administration and flushing the G-tube or at least every eight hours, start date 12/02/24, hold date 12/13/24 - 12/18/24;</li> <li>- An order to flush the G-tube with 60 milliliters (ml) of water after each bolus feed, every night shift, start date 12/02/24, hold date 12/13/24 - 12/18/24;</li> <li>- An order for Jevity 1.5 cal (oral liquid nutritional supplement) 200 ml via G-tube every night shift related to abnormal weight loss. Administer at 8 P.M. and 2 A.M., start date 12/01/24;</li> <li>- Weekly weights every Monday, dated 02/26/24;</li> <li>- No physician orders to hold the G-tube feedings and the water flushes from 12/02/24 - 12/13/24.</li> </ul> <p>Review of the resident's Treatment Administration Record (TAR), dated December 2024, showed:</p> <ul style="list-style-type: none"> <li>- Check the G-tube placement before initiation of formula, medication administration and flushing the G-tube or at least every eight hours, start date 12/02/24, hold date 12/13/24 - 12/18/24, with 19 opportunities missed out of 22 opportunities for 12/02/24 - 12/13/24;</li> </ul> <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> <li>- Flush G-tube with 60 milliliters (ml) of water after each bolus feed, every night shift, start date 12/02/24, hold date 12/13/24 - 12/18/24, with nine opportunities missed out of 12 opportunities for 12/02/24 - 12/13/24;</li> <li>- Jevity 1.5 cal 200 ml via G-tube every night shift related to abnormal weight loss. Administer at 8 P.M. and 2 A.M., start date 12/01/24, with nine opportunities missed out of 12 opportunities for 12/02/24 - 12/13/24.</li> <li>- Weigh weekly every day shift every Monday, dated 02/26/24. No documentation of weights on 12/02/24, 12/09/24, 12/16/24, 12/23/24, and 12/30/24, with five opportunities missed out of five opportunities;</li> <li>- The facility held the order for flushing and enteral feeding from 12/02/24 to 12/13/24 without an order.</li> </ul> <p>Review of the resident's emergency room Discharge paperwork, dated 12/01/24, showed:</p> <ul style="list-style-type: none"> <li>- Resident discharged from theER on [DATE];</li> <li>- Reason for the ER visit was a G-tube replacement;</li> <li>- Received abdomen x-ray, kidney, ureter, and bladder (KUB - abdominal x-ray) for tube placement.</li> </ul> <p>Review of the resident's emergency room paperwork, dated 12/01/24, showed:</p> <ul style="list-style-type: none"> <li>- Resident admitted to the hospital emergency outpatient on 12/01/24 at 7:14 P.M., and discharged to the facility on [DATE] at 9:37 P.M.;</li> <li>- Resident admitted due to having pulled out G-tube;</li> <li>- History of illness: Resident presented after pulling G-tube out. Patient reportedly pulled out an 18 French G-tube this afternoon, unsure of exact time;</li> <li>- Abdomen was normal, soft, nondistended, and nontender with skin turgor good;</li> <li>- At 8:12 P.M., front view of the abdomen showed the G-tube was in satisfactory position;</li> <li>- At 8:41 P.M., the G-tube was replaced, KUB done showing proper placement. Resident will be discharged back to nursing home to follow up with primary care physician.</li> </ul> <p>Review of the resident's progress notes showed:</p> <ul style="list-style-type: none"> <li>- On 12/01/22 at 6:55 P.M., while certified nursing assistant (CNA) got the resident into bed, the resident grabbed his/her G-tube and pulled it out with the bulb intact. Placed a dry dressing on the site after cleaning the area. Sent the resident to the ER via an ambulance;</li> </ul> <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> <li>- On 12/02/22 at 2:22 A.M., the resident came back to the facility after having a new G-tube placed in the ER. The ER called said they had replaced the G-tube using a catheter (a flexible tube inserted into the bladder to drain urine) for the new G-tube and the facility would need to let his/her primary care provider know about this in the morning. The resident came back on 12/1/24 at around 10:00 P.M., was awake and in good spirits upon returning. The resident slept well throughout the night so far. Faxed the physician to let him/her know;</li> <li>- On 12/04/24, Jevity and flush not administered as resident did not have a G-tube at this time, waiting for appointment with physician;</li> <li>- On 12/05/24, Jevity and flush not administered as unable to give at this time. Physician was aware;</li> <li>- On 12/06/24, an appointment with general surgery obtained for 12/13/24 at 1:30 P.M., for consult regarding G-tube replacement;</li> <li>- On 12/07/24, unable to access G-tube to check for placement;</li> <li>- On 12/08/24, unable to access G-tube;</li> <li>- On 12/09/24, no feedings during this shift, not able to give feeding due to not having the correct G-tube;</li> <li>- On 12/10/24, unable to check placement due to having urinary catheter from ER, resident had wrong type of G-tube. Director of Nursing (DON) was aware;</li> <li>- On 12/11/24, primary care physician was rounding on residents and unable to provide check, flush or feeding due to a catheter in place. Appointment for replacement already scheduled;</li> <li>- On 12/12/24, no changes see prior notes;</li> <li>- On 12/13/24, new order from physician to hold bolus feedings and flushes.</li> </ul> <p>Review of the resident's medical record showed:</p> <ul style="list-style-type: none"> <li>- No assessment of the G-tube site after the readmission from theER on [DATE];</li> <li>- No skin assessment completed after the resident returned from theER on [DATE].</li> </ul> <p>Review of the resident's weights, dated 11/4/24 - 01/08/25, showed:</p> <ul style="list-style-type: none"> <li>- On 11/04/24, a weight of 119.8 pounds;</li> <li>- On 11/12/24, a weight of 120.2 pounds;</li> <li>- On 11/26/24, a weight of 116.0 pounds;</li> <li>- On 12/06/24, a weight 117.2 pounds;</li> </ul> <p>(continued on next page)</p>

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> <li>- On 12/24/24, a weight of 118 pounds;</li> <li>- On 01/03/25, a weight of 116.2 pounds;</li> <li>- On 01/09/25, a weight of 118.2 pounds.</li> </ul> <p>Review of the resident's General Surgeon paperwork, dated 12/17/24, showed:</p> <ul style="list-style-type: none"> <li>- Physical exam showed G-tube in place, migrated in all the way, with an over inflated balloon;</li> <li>- Plan: G-tube adjusted at bedside, balloon was emptied and 10 ml of sterile water placed in;</li> <li>- The G-tube balloon was over inflated and migrated all the way in, it was believed this was obstructing the duodenum (first part of the small intestine).</li> </ul> <p>During an interview on 12/31/24 at 2:04 P.M., the DON said Resident #12 pulled out his/her G-tube on 12/01/24, and was sent to the ER. She received report from two different ER nurses when the resident returned from the ER. Both ER nurses told her they were not able to replace the resident's G-tube and the resident had a catheter in the opening to hold it open until it could be replaced. Based on the information she received from the ER, she made the resident an appointment as soon as possible to have the G-tube replaced. The resident did take in food orally and she discussed with the Registered Dietician (RD) to see if the G-tube could be discontinued, but the RD felt the resident was not ready for that yet. The RD did recommend the resident's feeding be reduced from twice a day to once a day. The DON said she was told by another facility nurse the physician had been notified about the resident not receiving the feedings and flushes. She did not have documentation of the physician notification before 12/13/24, when the physician ordered to hold the G-tube feedings until the resident's appointment with the surgeon.</p> <p>During an interview on 01/08/24 at 3:00 P.M., CNA D said he/she returned to work a day or two after Resident #12 returned from the ER with the new G-tube. The resident had the same G-tube that was there now, with purple caps on the end, the whole time.</p> <p>During an interview on 01/09/24 at 7:45 A.M., the Physician said he/she had not been notified of the facility holding Resident #12's G-tube feedings until 01/13/24. Thankfully, this resident also ate orally so there wasn't a bad outcome, but there was the potential. Based on the ER paperwork, the ER replaced the G-tube and the feedings and flushes shouldn't have been held to begin with. He/She did not assess the resident's G-tube on 01/13/24, and gave orders to hold the feedings and flushes from the nurse's report. It was the nurse's responsibility to assess the resident before contacting him/her. The resident's meals should have been documented and all weights completed, especially during that time frame. The resident should have been assessed after the resident returned from the ER to verify what tube the resident received.</p> <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 01/09/24 at 2:40 P.M., the DON said she could not remember which nurse told her the physician had been contacted prior to 12/13/24. She never looked at the resident's abdomen or tube to confirm it was a catheter and not a G-tube. She just went off the report from the ER. She didn't look at the ER discharge paperwork and no other nurses ever said anything different. It was the nurse's responsibility that accepted the resident from the ER to do a full assessment, look at the ER discharge paperwork, and ensure everything was correct. It was the DON's responsibility to ensure that happened. The DON said she should have assessed the resident's abdomen and viewed the tube. If she had done that, she would have known it was a G-tube.</p> <p>During an interview on 01/09/24 at 2:55 P.M., the Administrator said the resident should have been assessed and the tube looked at upon readmission. The discharge paperwork should have been looked at as well. The DON was in charge of ensuring the nurse on duty during readmission did that. A physician order to hold the feeding should have been received as well.</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45693</p> <p>Based on interview and record review, the facility failed to provide documentation of on-going assessments and monitoring after dialysis (a process for removing waste and excess water from the blood) center for one resident (Resident #36) out of one sampled resident. The facility's census was 47.</p> <p>Review of the facility's policy, Dialysis, undated showed:</p> <ul style="list-style-type: none"> <li>- This facility will ensure that residents who require dialysis receive such services consistent with professional standards of practice, the comprehensive person-centered care plan and the resident's goals and preferences;</li> <li>- The facility will ensure appropriate monitoring of the dialysis resident's status before, during, and after the treatments;</li> <li>- If this facility does not employ a qualified professional person to furnish dialysis treatments, the facility will enter into an agreement with a person or agency outside of the facility. This agreement constructs a connection between both entities and fosters accountability that is vital to the health of each resident and the success of their plan of care. Each end-stage renal disease (ESRD - a medical condition where the kidneys can no longer function to filter wastes or excess fluids from the blood) facility is responsible for ensuring the dialysis resident's needs and goals are addressed. The care plan will specify shared responsibilities divided between the nursing home and the ESRD facility, e.g., adhering to certain renal dietary restrictions based on the resident's fluid status.</li> </ul> <p>1. Review of Resident #36's Physician's Order Sheet (POS), dated January 2025, showed:</p> <ul style="list-style-type: none"> <li>- admitted on [DATE];</li> <li>- Diagnosis of ESRD;</li> <li>- No order for dialysis.</li> <li>- No order to assess the dialysis site and/or dressing before and after dialysis;</li> <li>- No order for vital signs and weights before and after dialysis.</li> </ul> <p>Review of the resident's quarterly Minimum Data Set (MDS - part of a federally mandated process for clinical assessment of all residents in certified nursing homes), dated 11/25/24, showed:</p> <ul style="list-style-type: none"> <li>- The resident received dialysis.</li> </ul> <p>Review of the resident's Care Plan, dated 08/27/24, showed:</p> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- Problem of dehydration and fluid maintenance with interventions to assess the resident's weight and vital signs before and after dialysis appointments, report concerns to the physician, and the resident received dialysis three times a week on Monday, Wednesday and Friday;</p> <p>- Did not address monitoring the resident's dialysis port (an implanted venous access device) dressing/site.</p> <p>Review of the resident's Dialysis Communication Reports, dated 12/09/24 - 01/08/25, showed:</p> <p>- Eight out of 14 opportunities missed for the vital signs and weights after dialysis;</p> <p>- Four out of 14 opportunities missed for the assessment of the dialysis site/dressing before dialysis;</p> <p>- Nine out of 14 opportunities missed for the assessment of the dialysis site/dressing after dialysis.</p> <p>During an interview on 01/07/25 at 9:45 A.M., Resident #36 said he/she went to dialysis on Mondays, Wednesdays, and Fridays. Staff did not observe his/her dialysis port every time but did sometimes. Staff sometimes took his/her vitals upon returning to the facility after dialysis, but not all of the time.</p> <p>During an interview on 01/09/25 at 2:40 P.M., Licensed Practical Nurse (LPN) D said the facility used a Dialysis Communication form that was filled out with the resident's vital signs, weight, and any changes the dialysis center should know prior to the resident leaving the facility for dialysis. The dialysis center filled out the second portion with the resident's vital signs and any changes the facility should know about prior to the resident leaving dialysis and returning to the facility. Upon the resident's return, staff should get a weight, vital signs, and look at the dressing covering the dialysis port since the site can't be seen. The form had another area at the bottom for the resident's return information. The receiving nurse was responsible for obtaining that information and documenting it.</p> <p>During an interview on 01/09/25 at 2:45 P.M., the Director of Nursing (DON) said the facility used a Dialysis Communication form that was filled out by the facility and the dialysis center to communicate back and forth. There was a final portion of the form at the bottom that should be filled out when the resident returned from dialysis. The last portion contained a weight, vital signs, and an assessment of the dialysis port dressing/site. A lot of the time, she received the resident back after dialysis, but if not, then the nurse receiving the resident back into the facility should complete the information. It was the DON's responsibility to ensure the form was completed.</p> <p>During an interview on 01/09/25 at 2:50 P.M., the Administrator said the facility used a Dialysis Communication form to communicate back and forth with the dialysis center. When the resident returned, the receiving nurse should fill out the bottom part of the form and assess the dialysis port dressing/site. It was the DON's responsibility to ensure the nurses were completing the form.</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>45693</p> <p>Based on interview and record review, the facility failed to limit the use of an as needed (PRN) order for psychotropic (medications that affect how the brain works and causes changes in mood, awareness, thoughts, feelings, or behaviors) medications to 14 days for three residents (Residents #17 and #30) out of two sampled residents and Resident #9 outside of the sample. The facility census was 47.</p> <p>The facility failed to provide a policy for the 14 day stop date on PRN psychotropic medications.</p> <p>1. Review of Resident #9's January 2025 Physician's Order Sheet (POS) showed:</p> <ul style="list-style-type: none"> <li>- Diagnosis of restlessness, agitation, and insomnia (difficulty sleeping);</li> <li>- An order for lorazepam (an anti-anxiety medication) 2 milligram (mg)/ milliliter (ml) 0.5 ml sublingually (under the tongue) every two hours PRN for restlessness, dated 11/18/24;</li> <li>- An order for lorazepam 0.5 mg tablet by mouth every four hours PRN for anxiety (persistent worry and fear about everyday situations), dated 11/27/24;</li> <li>- The facility did not provide a 14 day stop date order for the PRN lorazepam order.</li> </ul> <p>Review of the resident's medical record showed:</p> <ul style="list-style-type: none"> <li>- The resident's pharmacy Medication Record Reviews (MRR), dated 11/22/24 and 12/01/24, showed the resident had an order for lorazepam 2 mg/ml 0.5 mg every two hours PRN for restlessness and the pharmacist requested a 14 day stop date;</li> <li>- The physician did not address the need for the 14 day stop date of the PRN lorazepam order.</li> </ul> <p>2. Review of Resident #17's January 2025 POS showed:</p> <ul style="list-style-type: none"> <li>- Diagnoses of chronic obstructive pulmonary disease (COPD - a chronic inflammatory lung disease that causes obstructed airflow from the lungs), major depressive disorder (long-term loss of pleasure or interest in life), and anxiety disorder;</li> <li>- An order for lorazepam 2 mg/ml 0.5 ml by mouth every two hours PRN for anxiety, dated 11/09/24;</li> <li>- The facility did not provide a 14 day stop date order for the PRN lorazepam order.</li> </ul> <p>Review of the resident's medical record showed:</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- The resident's pharmacy MRR, dated 11/22/24 and 12/01/24, showed the resident had an order for lorazepam 2 mg/ml 0.5 mg every two hours PRN, and the pharmacist requested a 14 day stop date unless there was a documented rationale and anticipated duration of therapy;</p> <p>- The physician did not address the need for the 14 day stop date of the PRN lorazepam order.</p> <p>3. Review of Resident #30's January 2025 POS showed:</p> <p>- Diagnosis of anxiety disorder;</p> <p>- An order for hydroxyzine (an antihistamine used to treat anxiety) 25 mg by mouth every 12 hours PRN for anxiety related to anxiety disorder, dated 04/11/24;</p> <p>- The facility did not provide a 14 day stop date order for the PRN hydroxyzine order.</p> <p>Review of the resident's medical record showed:</p> <p>- The resident's pharmacy Gradual Dose Reduction (GDR) request, dated 10/18/24, showed the PRN hydroxyzine order must have a stop date if ordered for anxiety;</p> <p>- The physician did not address the need for the 14 day stop date of the PRN hydroxyzine order.</p> <p>During an interview on 01/09/25 at 12:03 P.M., the Director of Nursing (DON) said she was responsible for GDRs and MRRs. She tried to get the MRRs faxed to the physicians within two weeks of receiving the email from the pharmacist. She had not done November's or December's due to working the floor so often.</p> <p>47445</p>		

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NAME OF PROVIDER OR SUPPLIER  Aspire Senior Living Poplar Bluff		STREET ADDRESS, CITY, STATE, ZIP CODE  3001 May Street Poplar Bluff, MO 63901	

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>45693</p> <p>Based on observation, interview, and record review, the facility failed to label and store medications in a safe and effective manner when opened insulin was found undated in the medication cart and failed to ensure the medication cart was locked while unattended. This had the potential to affect all residents. The facility census was 47.</p> <p>Review of the facility policy titled, Storage of Medication, dated 01/20/24, showed:</p> <ul style="list-style-type: none"> <li>- Compartments containing medications are locked when not in use and should not be left unattended;</li> <li>- Narcotics should be double locked at all times.</li> </ul> <p>The facility failed to provide a policy regarding dating insulin pens.</p> <p>Review of the manufacturer's recommendations for Lantus (a long-acting type of insulin), dated June 2023, showed:</p> <ul style="list-style-type: none"> <li>- Discard the medication 28 days after opening.</li> </ul> <p>Review of the manufacturer's recommendations for lispro insulin pen (a fast acting type of insulin), dated 2023, showed:</p> <ul style="list-style-type: none"> <li>- Discard the medication 28 days after opening.</li> </ul> <p>Review of the manufacturer's recommendations for Admelog insulin pen (a fast acting type of insulin), dated August 2023, showed:</p> <ul style="list-style-type: none"> <li>- Discard the medication 28 days after opening.</li> </ul> <p>1. Observation on 01/08/25 at 11:14 A.M. - 11:19 A.M., of the Certified Medication Technician (CMT) medication cart showed:</p> <ul style="list-style-type: none"> <li>- The medication cart sat against the wall to the left of the medication prep room facing the hallway and unlocked.</li> </ul> <p>2. Observation on 01/08/25 at 11:27 A.M. - 11:30 A.M., of the CMT medication cart showed:</p> <ul style="list-style-type: none"> <li>- The medication cart sat against the wall to the left of the medication prep room facing the hallway and unlocked.</li> </ul> <p>3. Observation on 01/08/25 at 11:49 A.M., - 11:50 A.M., of the CMT medication cart showed:</p> <p>(continued on next page)</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- The medication cart sat against the wall to the left of the medication prep room facing the hallway and unlocked;</p> <p>- The CMT left the cart unlocked, walked to the medication prep room, then toward the front door, and returned to the cart.</p> <p>4. Observation on 01/09/25 at 9:46 A.M. - 10:25 A.M., of the nurse medication cart showed:</p> <p>- The medication cart sat in the hallway against the window of the medication prep room, facing the hallway, unlocked.</p> <p>5. Observation on 01/09/25 at 1:15 P.M., of the CMT medication cart showed:</p> <p>- Two labeled and opened lispro insulin pens, not dated;</p> <p>- Two labeled and opened Lantus insulin pens, not dated;</p> <p>- One labeled and opened Admelog insulin pen, dated 12/06/24, six days past the 28 day shelf life once opened.</p> <p>During an interview on 01/09/25 at 10:26 A.M., Licensed Practical Nurse (LPN) E said the cart should always be locked when left unattended. The narcotics should be double locked by ensuring the cart itself was locked.</p> <p>During an interview on 01/09/25 at 2:30 P.M., the Director of Nursing (DON) said insulin pens should be dated when opened. Medication carts should always be locked when left unattended.</p> <p>During an interview on 01/09/25 at 2:45 P.M., the Administrator said medication carts should always be locked when left unattended. Insulin pens and vials should be dated when opened and discarded in 28 days unless the manufacturer information was different than 28 days.</p>

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<p>F 0838</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies.</p> <p>45693</p> <p>Based on interview and record review, the facility failed to update the facility assessment (an assessment to determine what resources were necessary to care for residents competently during both day-to-day operations and emergencies) at least annually. The facility census was 47.</p> <p>Review of the facility's policy titled, The Purpose and Importance of a Facility Assessment, dated 08/07/24, showed:</p> <ul style="list-style-type: none"> <li>- Resident profile - the number of current residents and which of their needs have been identified, including physical, medical, ethic, cultural, or religious needs;</li> <li>- Care provided - what care and services are currently provided or offered to residents at the facility;</li> <li>- Resources needed - based on the needs identified in the resident profile, what the facility's staffing, equipment, and supplies are needed to properly care for the residents;</li> <li>- The assessment must be conducted, at a minimum, annually and updated as necessary. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment.</li> </ul> <p>Review of the facility's Matrix (a tool used to identify care categories for residents in a long term care facility), dated 01/08/25, showed:</p> <ul style="list-style-type: none"> <li>- One resident with a feeding tube (a small tube that's surgically inserted into the stomach through the abdomen).</li> </ul> <p>Review of the facility assessment, dated 08/07/24, showed:</p> <ul style="list-style-type: none"> <li>- The number of residents with intellectual and/or developmental disability not accurate per the facility census;</li> <li>- The assessment showed no residents with a feeding tube;</li> <li>- The assessment based on an average number of 40 residents;</li> <li>- Activities of Daily Living (ADLs) required assistance based on an average of 20 residents;</li> <li>- The competencies required by the facility did not include the resident with a feeding tube.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0838</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 01/09/24 at 2:45 P.M., the Administrator said said residents with feeding tubes should be included in the facility assessment. The facility had a resident with a feeding tube for multiple years. The average care required for ADLs should have been based off of a census of 40 residents instead of 20 residents. The information in the facility assessment should reflect what care was required in the facility and what staff competencies were required.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45693</b></p> <p>Based on observation, interview, and record review, the facility failed to maintain proper infection control practices during the hall tray meal pass, during incontinent care for two residents (Residents #24 and #40) out of four sampled residents, and during the medication pass for two residents (Residents #24 and #44) out of two sampled residents. The facility also failed to correctly screen five residents (Residents #4, #12, #20, #28, and #97) for tuberculosis (TB - an infectious disease characterized by the growth of nodules in the tissues, especially the lungs) out of five sampled residents required by state regulation 19 CSR 20-20.100. The facility census was 47.</p> <p>Review of the facility's policy titled, Hand Hygiene, dated 01/20/24, showed:</p> <ul style="list-style-type: none"> <li>- Handwashing will be regarded by this facility as the single most important means preventing the spread of infection;</li> <li>- Staff will follow the facility's established hand hygiene procedures to prevent the spread of infections and diseases to other staff, residents, and visitors: when coming on duty; whenever hands are visibly dirty; before having direct contact with a resident; after having direct contact with a resident; before preparing or handling medications; before handling clean or soiled dressings, gauze pads, etc; after handling used dressings, contaminated equipment, etc; after contact with blood, body fluids, excretions, secretions, mucous membranes, or non-intact skin; after handling items potentially contaminated with blood, body fluids, excretions, or secretions; before putting on gloves; after removing gloves.</li> </ul> <p>The facility did not provide a policy regarding hand hygiene during medication administration.</p> <p>Review of the facility's policy titled, Residents Tuberculosis Screening, dated 01/30/24, showed:</p> <ul style="list-style-type: none"> <li>- Residents will be screened for TB infections upon their admission to the facility and at intervals appropriate for the regional prevalence of TB, with screening performed at least annually;</li> <li>- Upon admission to the facility, the resident will be screened for TB;</li> <li>- If the PPD status is unknown or is known to have been negative in the past, the two-step TB skin test (TST) will be administered.</li> </ul> <p>1. Observation of the 200 Hall meal pass on 01/07/25 at 12:28 P.M. to 12:36 P.M., showed:</p> <ul style="list-style-type: none"> <li>- CNA B did not wear gloves, did not perform hand hygiene, carried a meal tray into room [ROOM NUMBER], uncovered the plate, touched the resident's bed side commode, moved the bedside table to the resident, picked up a cup of milk from the nightstand, touched his/her own face, did not perform hand hygiene, and exited the room;</li> <li>- CNA B did not wear gloves, did not perform hand hygiene, retrieved a meal tray from the meal cart, uncovered the plate, entered room [ROOM NUMBER] with the tray, exited the room, and did not perform hand hygiene;</li> </ul> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- CNA B pushed the meal cart down the hall, did not wear gloves, did not perform hand hygiene, took a meal tray into room [ROOM NUMBER], uncovered the plate, uncovered the resident, touched the resident's shoes, assisted the resident to sit on the side of the bed, moved the bed side table, touched the napkin and utensils on the tray, touched the cup of fruit, did not perform hand hygiene, and exited the room;</p> <p>- CNA B did not wear gloves, did not perform hand hygiene, retrieved a meal tray from the cart and carried it into room [ROOM NUMBER], uncovered the plate, touched the resident's rollator (a walking frame equipped with wheels), assisted the resident to sit up in bed, touched the bedside table, touched a lantern light (a battery operated light), touched the fruit cup, did not perform hand hygiene and exited the room;</p> <p>- CNA B pushed the meal cart down the hallway, did not wear gloves, did not perform hand hygiene, took a meal tray into room [ROOM NUMBER], uncovered the plate, touched the bedside table, did not perform hand hygiene, and exited the room;</p> <p>- CNA B did not wear gloves, did not perform hand hygiene, retrieved a meal tray from the meal cart, uncovered the plate, took the meal tray into room [ROOM NUMBER], did not perform hand hygiene, and exited the room;</p> <p>- CNA B did not wear gloves, did not perform hand hygiene, retrieved a meal tray from the meal cart, took it into room [ROOM NUMBER], uncovered the plate and placed the tray on the resident's lap, touched the napkin, picked up two cups of chocolate shakes from another table, set them on the meal tray, touched the fruit cup, did not perform hand hygiene, and exited the room.</p> <p>During an interview on 01/09/25 at 2:45 P.M., the Director of Nursing (DON) and the Administrator said staff should sanitize hands between passing trays to each resident.</p> <p>2. Observation of Resident #24's incontinent care on 01/08/25 at 11:38 A.M., showed:</p> <p>- Resident #24 lay in bed;</p> <p>- Certified Nursing Assistant (CNA) C performed hand hygiene, put on gloves, unfastened and lowered the resident's brief soiled with urine and fecal matter between his/her legs, performed incontinent care but did not clean under the resident's scrotum, penis, or pull back the foreskin of the penis;</p> <p>- CNA C did not change gloves, did not perform hand hygiene, touched the television remote on the bed, rolled the resident to the right side, removed the glove from the left hand, did not perform hand hygiene, retrieved a trash bag and a glove from his/her pocket, put a glove on the left hand, cleaned fecal matter from the resident's buttocks with a wipe, folded the incontinent pad soiled with fecal matter under the resident, rolled the resident to the left side, removed the soiled incontinent pad, and placed in a trash bag;</p> <p>- CNA C did not change gloves, did not perform hand hygiene, placed and secured a clean brief on the resident, put pants and shoes on the resident, and removed the gloves;</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- CNA C did not perform hand hygiene, did not put on clean gloves, assisted the resident to sit on the bedside while touching the resident's hands and back, put on the resident's shirt, touched the resident's left armrest and the brake handles of the wheelchair, placed a gait belt around the resident's waist, transferred the resident to the wheelchair, removed the gait belt, placed the resident's hat on the resident, and placed a green wedge under the resident's left arm;</p> <p>- CNA C did not perform hand hygiene, removed clean gloves from his/her pocket, put on the gloves, removed the trash from the trash can, picked up the trash bag with soiled linen, touched the inside of the room doorknob, took the bags to soiled utility room, placed the trash in the trash barrel with a lid, opened the soiled linen bag and rinsed the soiled incontinent pad and placed in a barrel with a lid, removed gloves and performed hand hygiene.</p> <p>3. Observation of Resident #40's incontinent care on 01/08/25 at 3:15 P.M., showed:</p> <p>- Resident #40 lay in bed;</p> <p>- CNA A performed hand hygiene and put on gloves;</p> <p>- CNA A unfastened and lowered the resident's urine soiled brief;</p> <p>- CNA A cleaned the resident's front peri area;</p> <p>- CNA A did not perform hand hygiene, did not change gloves, assisted the resident to turn to the left, cleaned fecal matter from the rectal area, and cleaned the buttocks and hips;</p> <p>- CNA A did not perform hand hygiene, did not change gloves, removed the brief from under the resident and placed a clean brief under the resident;</p> <p>- CNA A removed the gloves, did not perform hand hygiene, put on gloves, and assisted the resident to his/her back and fastened the brief, positioned the resident, covered the resident with the blanket, and placed the call light in reach of the resident.</p> <p>During an interview on 01/09/25 at 12:28 P.M., CNA A said hands should be sanitized/washed and gloves changed between dirty and clean care and when going from one area to another.</p> <p>During an interview on 01/09/25 at 12:35 P.M., CNA C said hands should be washed when walking into the resident's room and put on gloves, perform incontinent care front to back using a new wipe each time, get dirty items out and put into a bag, change gloves wash hands, put clean brief and clothing on the resident, and transfer using a gait belt if needed. If a male resident allowed, should pull back the skin of the uncircumcised penis, clean it, and put the skin back. If the resident didn't allow it, then it was done during a shower.</p> <p>During an interview 01/09/25 at 12:40 AM the DON said she would expect staff to wash/sanitize hands before and after care, when going from dirty to clean care, and to different areas. Hand hygiene should be done before putting on clean gloves.</p> <p>4. Observation on 01/09/25 at 7:22 A.M., of Resident #44's medication administration showed:</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- Certified Medication Technician (CMT) I removed the resident's 13 medications from the bubble pack into his/her bare hand, and placed the medications into the medication cup;</p> <p>- CMT I poured four medications into the bottle lids, emptied the four medications from the bottle lids into his/her bare hand, and placed them into the medication cup;</p> <p>- CMT I administered the medication in the medication cup to the resident.</p> <p>5. Observation on 01/09/25 at 7:27 A.M., of Resident #24's medication administration showed:</p> <p>- CMT I removed the resident's 14 medications from the bubble pack into his/her bare hand and placed the medications into the medication cup;</p> <p>- CMT I poured two medications into the medication bottle lids, emptied the two medications from the bottle lids into his/her bare hand, and placed them into the medication cup;</p> <p>- CMT I administered the medications in the medication cup to the resident.</p> <p>During an interview on 01/09/25 at 2:45 P.M., the DON and the Administrator said staff should never touch medications with their bare hands.</p> <p>6. Review of Resident #5's medical record showed:</p> <p>- admitted [DATE];</p> <p>- Annual TB screen, dated 12/15/23;</p> <p>- No annual TST or screening completed for 2024.</p> <p>7. Review of Resident #12's medical record showed:</p> <p>- admitted [DATE];</p> <p>- Annual TB screen, dated 12/12/23;</p> <p>- No annual TST or screening completed for 2024.</p> <p>8. Review of Resident #20's medical record showed:</p> <p>- admitted [DATE];</p> <p>- First step TST administered on 12/11/23, and read on 12/14/23;</p> <p>- Second step TST administered on 12/19/23, and read 12/22/23;</p> <p>- No annual TST or screening completed for 2024.</p> <p>7. Review of Resident #28's medical record showed:</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- admitted [DATE];</p> <p>- First step TST administered on 12/11/23, and read on 12/14/23;</p> <p>- Second step TST administered on 12/19/23, and read on 12/22/23;</p> <p>- No annual TST or screening completed for 2024.</p> <p>8. Review of Resident #97's medical record showed:</p> <p>- admitted [DATE];</p> <p>- No TST or screening record of initial two step TST since admission.</p> <p>During an interview on 01/09/25 at 2:45 P.M., the Administrator and Director of Nursing (DON) said it was expected that residents receive a two step TST upon admission and then an annual sign and symptom screening thereafter.</p> <p>47445</p>