

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 04/23/2026
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)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to perform hand hygiene and change gloves during care for six residents (Residents #17, #32, #33, #35, #44, and #57) out of seven sampled residents, failed to follow Enhanced Barrier Precautions (EBP - precautions for use during high-contact resident care activities for residents infected with a multidrug-resistant organism (MDRO - microorganisms that are resistant to one or more classes of antimicrobial agents) or any resident who has a chronic wound and/or indwelling medical device) for three residents (Residents #4, #5, and #44) out of four sampled residents, failed to do annual tuberculosis (TB - infectious disease caused by the tubercle bacillus) screenings for three residents (Residents #5, #8, and #9) out of five sampled residents, and failed to keep hot water temperatures between 110 degrees Fahrenheit (°F) and 120°F to inhibit the growth of Legionella (bacteria that can be present in building water systems under ideal conditions and cause a severe type of pneumonia and mild flu-like illness). The facility census was 50. Review of the facility's policy titled, Hand Hygiene, dated 10/01/25, showed: - All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors; - Hand hygiene means cleaning your hands by handwashing with soap and water or the use of an antiseptic hand rub, also known as alcohol-based hand rub (ABHR); - Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice; - The use of gloves does not replace hand hygiene. If the task requires gloves, perform hand hygiene prior to putting on gloves, and immediately after removing gloves; - Perform hand hygiene between resident contacts, after handling contaminated objects, before preparing or handling medications, before applying and after removing personal protective equipment (PPE), before and after handling clean or soiled dressings, after handling items potentially contaminated with fluids, when moving from a contaminated body site to a clean body site. Review of the facility's policy titled, Enhanced Barrier Precautions, dated 10/01/25, showed: - It is the policy of this facility to implement EBP for the prevention of transmission of MDRO; - An order for EBP will be obtained for residents with wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO; and infection or colonization with a Centers for Disease Control and Prevention (CDC)-targeted MDRO when contact precautions (precautions that reduce the risk of transmission of infectious materials by direct contact) do not (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	otherwise apply; - Make gowns and gloves available for each resident requiring EBP; - PPE for EBP is only necessary when performing high-contact care activities and may not need to be put on prior to entering the resident's room; - High-contact resident care activities include dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use, and wound care. Review of the facility's policy titled, Guidelines for Screening for Tuberculosis In Long Term Care Facilities, dated May 2015, showed: - Residents are to be evaluated, at least annually, to ensure absence of signs and symptoms for tuberculosis disease. Review of the facility's policy titled, Legionella Surveillance, dated 04/14/22, showed: - Legionella surveillance is one component of the facility's water management plans for reducing the risk of Legionella and other opportunistic pathogens in the facility's water system; - Cooling towers and potable water systems shall be routinely maintained; - Cold water shall be stored and distributed below 68°F; - Hot water shall be stored above 140°F and circulated at a minimum return temperature of 124°F. Review of the facility's Monthly Water Management Checklist, undated, showed: - Water heaters, showerheads, hoses, and sinks should have a hot water temperature between 110°F and 120°F. 1. Observation on 04/20/26 at 4:03 P.M. of Resident #4's intravenous (IV &ndash; administered into a vein) antibiotic administration showed: - No EBP signage and no PPE outside of the resident's room; - Licensed Practical Nurse (LPN) G and LPN L entered the resident's room, performed hand hygiene, put on gloves, and did not put on gowns; - LPN G removed the disinfection cap from the IV tubing port, disinfected the port with an alcohol pad, flushed the port with a normal saline (salt water) flush, did not disinfect the port, and attached the IV antibiotic to the port. During an interview on 04/21/26 at 12:25 P.M., LPN G said he/she was not familiar with EBP and did not know he/she needed to wear a gown for IV medication administration. 2. Observation on 04/21/26 at 8:43 A.M., of Resident #17's medication pass showed: (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- Certified Medication Technician (CMT) C performed hand hygiene, did not put on gloves, and administered fluticasone (a corticosteroid medication) 50 microgram (mcg) spray to each nostril for the resident; - CMT C performed hand hygiene, did not put on gloves, and applied a lidocaine (used to treat localized pain) external patch 4 percent (%) to the right back for the resident. During an interview on 04/23/26 at 9:08 A.M., CMT D said gloves were worn when administering nose sprays. Gloves should also be worn when applying lidocaine patches. During an interview on 04/23/26 at 4:00 P.M., the Director of Nursing (DON) said gloves should be worn when applying lidocaine patches or when administering nasal sprays. 3. Observation on 04/21/26 at 10:04 A.M., of Resident #57's incontinent care showed: - Certified Nurse Aide (CNA) E and CNA F entered the resident's room, performed hand hygiene, and put on gloves; - CNA F performed the resident's incontinent care, did not perform hand hygiene, did not change gloves, put a clean brief on the resident, changed gloves, did not perform hand hygiene, rolled the resident to the right and left side, placed clean linens under the resident, and pulled the resident up in bed; got a wipe and wiped Resident #57's front peri area with four wipes; - CNA E and CNA F removed gloves, performed hand hygiene, and exited the room. During an interview on 04/21/26 at 10:30 A.M., CNA E said he/she should wash hands when going from dirty to clean care. He/She said EBP was for precautions and should wear gowns and gloves during care. Residents with wounds and catheters were on EBP. He/She changed gloves and washed hands even more often with people on EBP. 4. Observation on 04/21/26 at 10:47 A.M., of Resident #44's urinary catheter (a sterile tube inserted into the bladder to drain urine) care and incontinent care showed: - EBP signage outside of the resident's room; - CNA I entered the resident's room, performed hand hygiene, put on gloves, and did not put on a gown; - CNA I removed the catheter stabilization device, unfastened the resident's brief and tucked the brief soiled with fecal material under the resident, did not perform hand hygiene, did not change gloves, wiped the catheter tubing away from insertion site with the same area of the washcloth twice, performed hand hygiene, changed gloves, wiped the catheter tubing away from the insertion site with the same area of the washcloth twice, did not perform hand hygiene, and did not change gloves; - CNA I removed the brief soiled with fecal material, cleaned the fecal material from the resident's buttocks, did not perform hand hygiene, did not change gloves, and placed a clean brief under the resident, fastened the brief, fastened the catheter stabilization device, and touched the bed sheet, the blanket, the bed control, the fall mat, the resident's drinking cup and straw, and the call light; (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- CNA I removed the gloves, performed hand hygiene, and exited the resident's room. 5. Observation on 04/21/25 at 12:05 P.M., of Resident #5's gastrostomy tube (g-tube & a tube surgically inserted into the stomach to provide hydration, nutrition, and medications) feeding administration, water flushes (used to maintain the resident's hydration and to prevent the g-tube from clogging), and g-tube site dressing change showed: - EBP signage outside of the resident's room; - LPN B and LPN E entered the resident's room, performed hand hygiene, put on gloves, and did not put on gowns; - LPN G administered the g-tube feeding and the water flushes and performed the g-tube site dressing change; - LPN B and LPN G removed the gloves, performed hand hygiene, and exited the resident's room. During an interview on 04/21/25 at 12:25 P.M., LPN G said gowns were not needed during g-tube feeding administration, water flushes, and g-tube site dressing changes. He/She said the EBP signage outside the resident's room must be old because he/she was not aware the resident required EBP. 6. Observation on 04/22/26 at 5:22 A.M., of Resident #32's incontinent care showed: - CNA I and CNA M entered the resident's room, performed hand hygiene, and put on gloves; - CNA I performed the resident's incontinent care, removed the brief soiled with urine, did not perform hand hygiene, did not change gloves, placed a clean brief under the resident, put clean pants on the resident, and rummaged through the resident's sock drawer; - CNA I and CNA M removed gloves, performed hand hygiene, and exited the resident's room. 7. Observation on 04/22/26 at 5:37 A.M., of Resident #35's incontinent care showed: - CNA I and CNA M entered the resident's room, performed hand hygiene, and put on gloves; - CNA I performed the resident's incontinent care, removed the brief soiled with urine, did not perform hand hygiene, did not change gloves, placed a clean brief under the resident, put clean pants on the resident, rummaged through the resident's sock drawer, put clean socks on the resident, and touched the resident's shirt; - CNA I and CNA M removed the gloves, performed hand hygiene, and exited the resident's room. During an interview on 04/22/26 at 1:57 P.M., CNA I said hand hygiene should be performed when entering and leaving a resident's room and between dirty to clean tasks. He/She said gloves should be changed from dirty to clean tasks. 8. Observation on 04/22/26 at 10:35 A.M., of Resident #33's incontinent and urinary catheter care showed: (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- No EBP signage outside of the resident's room; - CNA H and CNA I entered the resident's room, performed hand hygiene, and put on gowns and gloves; - CNA H performed the urinary catheter care, did not perform hand hygiene or change gloves, cleaned fecal material from the resident's buttocks, did not perform hand hygiene, did not change gloves, placed a clean brief on the resident, picked up the urinary catheter drainage bag and tubing and threaded it through the leg of the brief, and hung the urinary catheter drainage bag on the bedframe, and adjusted the resident's blankets; - CNA H and CNA I removed gloves, performed hand hygiene, and exited the resident's room. During an interview on 04/22/26 at 10:45 A.M., CNA H said he/she should have changed gloves and performed hand hygiene between dirty and clean tasks. 9. Review of Resident #5's medical record showed: - admission date of 05/21/20; - No annual screening for tuberculosis for February 2025 &ndash; April 2026. 10. Review of Resident #8's medical record showed: - admission date of 05/08/23; - No annual screening for tuberculosis for February 2025 &ndash; April 2026. 11. Review of Resident #9's medical record showed: - admission date of 11/14/19; - No annual screening for tuberculosis for February 2025 &ndash; April 2026. During an interview on 04/23/26 at 2:32 P.M., LPN J said he/she would expect tuberculosis screenings to be performed on all residents at least yearly. During an interview on 04/23/26 at 3:30 P.M., the DON said residents with indwelling devices and chronic wounds should be on EBP and staff should be wearing a gown and gloves during high-contact care. Hand hygiene should be performed when entering and exiting a room and between residents. She would expect yearly TB screenings to be performed on all residents. 12. Review of the facility's Water Temperature Checks, dated 03/30/26, showed: - Water temperature in room [ROOM NUMBER] of 96°F; - Water temperature in room [ROOM NUMBER] of 100°F; - Water temperature in room [ROOM NUMBER] of 109°F; (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- Water temperature in room [ROOM NUMBER] of 106°F; - Water temperature in room [ROOM NUMBER] of 108°F; - Water temperature in room [ROOM NUMBER] of 107°F; - Water temperature in room [ROOM NUMBER] of 105°F; - Water temperature in room [ROOM NUMBER] of 107°F; - Water temperature in room [ROOM NUMBER] of 104°F. Review of the facility's Water Temperature Checks, dated 04/06/26, showed: - Water temperature in room [ROOM NUMBER] of 96°F; - Water temperature in room [ROOM NUMBER] of 92°F; - Water temperature in room [ROOM NUMBER] of 102°F; - Water temperature in room [ROOM NUMBER] of 105°F; - Water temperature in room [ROOM NUMBER] of 102°F; - Water temperature in room [ROOM NUMBER] of 105°F; - Water temperature in room [ROOM NUMBER] of 100°F; - Water temperature in room [ROOM NUMBER] of 97°F. Review of the facility's Water Temperature Checks, dated 04/13/26, showed: - Water temperature in room [ROOM NUMBER] of 104°F; - Water temperature in room [ROOM NUMBER] of 70°F; - Water temperature in room [ROOM NUMBER] of 80°F; - Water temperature in room [ROOM NUMBER] of 80°F; - Water temperature in room [ROOM NUMBER] of 108°F; - Water temperature in room [ROOM NUMBER] of 108°F. Review of the facility's Water Temperature Checks, dated 04/21/26, showed: - Water temperature in room [ROOM NUMBER] of 90°F; - Water temperature in room [ROOM NUMBER] of 92°F; (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- Water temperature in room [ROOM NUMBER] of 106°F; - Water temperature in room [ROOM NUMBER] of 105°F; - Water temperature in room [ROOM NUMBER] of 105°F; - Water temperature in room [ROOM NUMBER] of 106°F; - Water temperature in room [ROOM NUMBER] of 95°F; - Water temperature in room [ROOM NUMBER] of 101°F. Observation on 04/23/26 at 8:44 A.M., of room [ROOM NUMBER] showed: - Water temperature from the sink of 73.7°F. Observation on 04/23/26 at 8:56 A.M., of room [ROOM NUMBER] showed: - Water temperature from the sink of 98°F. Observation on 04/23/26 at 9:24 A.M., of room [ROOM NUMBER] showed: - Water temperature from the shower of 92°F. Observation on 04/23/26 at 9:29 A.M., of room [ROOM NUMBER] showed: - Water temperature from the sink of 84.7°F. Observation on 04/23/26 at 9:35 A.M., of room [ROOM NUMBER] showed: - Water temperature from the sink of 98.5°F. During an interview on 04/23/26 at 2:35 P.M., the Maintenance Supervisor said water temperatures for Legionella growth was 105°F to 110°F. He said the water temperatures were adjusted at the water heater when they were out of range. During an interview on 04/23/26 at 3:30 P.M., the Administrator said hot water temperatures should be between 105°F and 120°F to inhibit growth of legionella. He said he would expect yearly TB screenings to be performed on all residents.		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on interview and record review, the facility failed to inform residents and/or their responsible parties, in advance of the risks and benefits of proposed care, when the facility failed to obtain written consent before beginning psychotropic medications (medications that affect the mind, emotions, and behavior) for five residents (Residents #4, #6, #18, #24, and #57) out of seven sampled residents. The facility census was 50. Review of the facility policy titled, Use of Psychotropic Medications, dated 10/01/25, showed: - Prior to initiating or increasing a psychotropic medication, the resident, family, and /or resident representative must be informed of the benefits, risks, and alternative for the medication; - The resident has the right to accept or decline the initiation on increase of a psychotropic medication; - The facility will document that the resident or resident representative was informed in advance of the risks and benefits of the proposed care, the treatment alternative or other options, and the preferred option to accept or decline in a format that facility deems to use. 1. Review of Resident #4's medical record showed: - admission date of 11/06/23; - Diagnoses of unspecified dementia (a cognitive decline such as memory loss, confusion, and communication problems exists, but the underlying cause cannot be clearly identified), major depressive disorder (persistent, severe sadness, low mood, or loss of interest in activities lasting at least two weeks), cognitive communication deficit (problems with communication that have an underlying cause in a cognitive deficit rather than a primary language or speech), and anxiety disorder (excessive, persistent fear or worry that interferes with daily life); - An order for buspirone (an antianxiety medication) 15 milligrams (mg) by mouth three times a day for depression, dated 11/22/25; - An order for doxepin (an antidepressant medication) 10 mg by mouth one time a day for skin picking, dated of 04/09/26; - An order for duloxetine (an antidepressant medication) 30 mg by mouth one time a day for major depressive disorder, dated 12/02/24; - An order for Rexulti (an antipsychotic (medication used to treat psychosis & symptoms like hallucinations, delusions, and disorganized thinking) medications) 0.5 mg by mouth one time a day for dementia, dated 01/13/26; - No documentation consents or education on risks and benefits were provided to the resident and/or their representative for buspirone, doxepin, duloxetine, and Rexulti. 2. Review of Resident #6's medical record showed: - admission date of 09/03/24; (continued on next page)		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Diagnoses of adjustment disorder with depressed mood (a short-term mental health condition occurring when intense sadness, hopelessness, and sadness arise in response to a specific life stressor), anxiety disorder, and other amnesia (memory loss); - An order for buspirone 10 mg by mouth two times a day for anxiety, dated 12/10/24; - An order for citalopram (an antidepressant medication) 20 mg by mouth one time a day for depression, dated 04/04/26; - An order for mirtazapine (an antidepressant medication) 15 mg one tablet by mouth in the evening related to anxiety disorder, dated 11/18/24; - A psychotropic medication informed consent for citalopram, that did not list non-pharmacological approaches, beneficial effects, or possible side effects, dated 04/03/26; - No documentation of consents or education of risks and benefits were provided to the resident and/or their representative for the mirtazapine and buspirone medications. 3. Review of Resident #18's medical record showed: - admission date of 11/06/25; - Diagnoses of dementia, psychotic disorder with delusions, and anxiety; - An order for Seroquel (an antipsychotic medication) 50 mg by mouth at bedtime for psychotic disorder with delusions, dated 04/07/26; - An order for Zoloft (an antidepressant medication) 25 mg by mouth one time a day related to anxiety disorder, dated 01/11/26; - An order for lorazepam (an antianxiety medication) 0.5 mg by mouth two times a day related to anxiety, dated 01/28/26; - An order for Seroquel 50 mg by mouth three times a day related to psychotic disorders with delusions, dated 04/07/26; - No documentation of consents or education of risks and benefits were provided to the resident and/or their representative for the Seroquel, Zoloft, and lorazepam. 4. Review of Resident #24's medical record showed: - admission date of 02/13/26; - Diagnoses of Parkinson's disease (brain disorder causing unintended or uncontrolled movements) and psychophysiologic insomnia (difficulty sleeping due to excessive worry about sleep); - An order for buspirone 10 mg by mouth three times a day for anxiety and depression, dated 02/13/26; (continued on next page)		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- An order for fluoxetine (an antidepressant medication) 20 mg by mouth one time a day for depression and anxiety, dated 03/08/26; - An order for olanzapine (an antipsychotic medication) 15 mg by mouth one time a day for bipolar disorder (mood disorder that can cause intense mood swings), dated 02/13/26; - An order for trazodone (an antidepressant medication) 50 mg by mouth one time a day for pain, dated 02/13/26; - No documentation of consents or education on risks and benefits were provided to the resident and/or their representative for buspirone, fluoxetine, olanzapine, and trazodone. 5. Review of Resident #57's medical record showed: - admission date of 04/13/26; - Diagnoses of chronic obstructive pulmonary disease (COPD &ndash; a lung disease) and atrial fibrillation (abnormal heart rhythm); - An order for amitriptyline (an antidepressant medication) 150 mg by mouth one time a day for depression, dated 04/14/26; - No documentation of consents or education of risks and benefits were provided to the resident and/or their representative for the amitriptyline. During an interview on 04/23/26 at 2:45 P.M., Licensed Practical Nurse (LPN) A and LPN J said they did psychotropic evaluations on admission but did not know if that was the same thing as consents. During an interview on 04/23/26 at 2:48 P.M., the Regional QA Nurse said psychotropic consents were going to be addressed by educating staff. Right now, some psychotropic consents were completed, some were filled out wrong, and some were not completed. During an interview on 04/23/26 at 3:30 P.M., the Administrator and the Director of Nursing (DON) said they have psychotropic medication consents, and they would expect the residents and/or their representatives to be informed, in advance of care, of the risks and benefits and possible alternative treatments for psychotropic medications. During an interview on 04/23/26 at 3:30 P.M., the DON said the Infection Preventionist was responsible for getting the psychotropic medication consents completed.		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure an order for code status was consistently documented throughout the medical record for one resident (Resident #58) out of 15 sampled residents. The facility census was 50. Review of the facility's policy titled, Basic Life Support/Cardiopulmonary Resuscitation (CPR - an emergency procedure consisting of chest compressions if the heart stops beating or the person stops breathing), dated [DATE], showed:- Potential rescuers will initiate CPR, in addition to calling 911, unless a valid Do Not Resuscitate (DNR - does not want cardiopulmonary resuscitation) order is in place, obvious signs of irreversible death (e.g., rigor mortis, dependent lividity, decapitation, transection or decomposition) are present, or initiating CPR could cause injury or peril to the rescuer; - If a resident experiences a cardiac or respiratory arrest and the resident does not show obvious clinical signs of irreversible death (e.g. rigor mortis, dependent lividity, decapitation, transection, or decomposition), the facility must provide basic life support, including CPR, prior to the arrival of emergency medical services: in accordance with the resident's advance directives and any related physician order, such as code status or in the absence of advance directives or a DNR order;- Facility policy will address how resident preferences and physician orders related to CPR and other advance directive issues are communicated throughout the facility so that staff know immediately what action to take or not take when an emergency arises;- Resident wishes expressed through a resident representative must also be honored, although again physician orders should be obtained as soon as possible. 1. Review of Resident #58's medical record showed:- admission date of [DATE];- A DNR code status indicated on the Outside the Hospital Do Not Resuscitate Order (OHDNR) form, with verbal consent obtained from the resident representative and signed by the physician, dated [DATE];- An order to admit to hospice, dated [DATE];- An order for full code (wants CPR if the heart stops beating or the person stops breathing) status, dated [DATE]. Review of the resident's hospice binder showed:- A DNR code status. Review of the resident's care plan, initiated [DATE], showed:- Resident will be a full code;- Resident will receive full CPR interventions in the event of cardiac and respiratory arrest;- Code status will be reassessed on a quarterly basis and as needed. During an interview on [DATE] at 2:00 P.M., the Director of Nursing (DON) said she worked for the same hospice company prior to becoming the DON at the facility. She admitted the resident to hospice at the facility while she previously worked for hospice and the resident was a DNR at that time. The resident's responsible party wanted the resident's code status changed to full code because they were worried the resident wouldn't get good care as a DNR. The resident's code status was changed in the electronic medical record (EMR) to a full code, but the code status was not changed in the resident's hospice binder. It was the responsibility of the hospice staff to update the hospice binder. She would expect staff to look at the EMR or the code status book at the nurse's station to verify a resident's code status. She would also expect a resident's code status to be consistently documented throughout the medical record, including the hospice binder. During an interview on [DATE] at 9:00 A.M., Licensed Practical Nurse (LPN) A said Resident #58's hospice binder showed the resident was DNR and the EMR showed the resident was a full code. A resident's code status should be consistently documented throughout the medical record, including the hospice binder. During an interview on [DATE] at 3:45 P.M., LPN G said he/she would look in the EMR to verify a resident's code status. A resident's code status should be consistently documented throughout the medical record. During an interview on [DATE] at 1:04 P.M., the Medical Records Director said the Social Services Designee (SSD) or the admission Coordinator were responsible for asking the residents about Advance Directives and code status when they assist the resident to fill out the admission paperwork to the facility. She updated the EMR immediately with any changes and verified the EMR was correct every Monday. During an interview on [DATE] at 1:00 (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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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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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	P.M., the Administrator said he would expect a resident's code status to be consistently documented throughout the medical record. Complaint #2985554		

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on interview and record review, the facility failed to issue a Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN) and/or a Notice of Medicare Non-Coverage (NOMNC) form to the resident and/or the resident's representative in writing at least two calendar days before discharge from skilled services. This notice informs the beneficiary about potential non-coverage services and the option to continue services with the beneficiary accepting the financial liability for those services. This practice affected one resident (Resident #29) out of three sampled residents. The facility census was 50. Review of the facility policy titled, Advance Beneficiary Notices, dated 10/01/25, showed:- The Business Office Manager is the contact person for information regarding Medicare eligibility, coverage, and applying for benefits;- The facility shall inform Medicare beneficiaries of his or her potential liability for payment;- A liability notice shall be issued to Medicare beneficiaries upon admission or during a resident's stay before the facility provides an item or service that is usually paid for by Medicare, but may not be paid for in a particular instance because it is not medically reasonable and necessary;- For Part A Medicare services, the facility shall use the SNF ABN form;- A NOMNC shall be issued to the resident or resident representative when Medicare covered services are ending, no matter if the resident is leaving the facility or remaining in the facility;- To ensure that the resident, or representative, has enough time to make a decision whether or not to receive the services in question and assume financial responsibility, the notice shall be provided at least two days before the end of a Medicare covered stay;- The notices must not be provided while the resident/representative is under duress or in an emergency situation;- The Business Office Manager, or designee, is responsible for issuing notices;- The facility shall issue a notice each time, and as soon as, it makes the assessment that Medicare payment certainly or probably will not be made. 1. Review of Resident #29's medical record showed:- The resident discharged from skilled Medicare services on 04/11/26, and remained in the facility;- The resident received a SNF ABN on 04/11/26;- The resident received a NOMNC on 04/11/26;- The facility failed to provide the SNF ABN and NOMNC forms to the resident and/or the representative at least two calendar days before the skilled Medicare services ended. During an interview on 04/23/26 at 3:30 P.M., the Business Office Manager said the SNF ABN and NOMNC forms were to be given at least two days before a resident's benefits ended. During an interview on 04/23/26 at 3:30 P.M., the Administrator said he would expect SNF ABN and NOMNC forms be given two days before the end of skilled Medicare services ended. ervices.		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on interview and record review, the facility failed to attempt a gradual dose reduction (GDR) for psychotropic (medications that affect how the brain works and causes changes in mood, awareness, thoughts, feelings, or behaviors) medications for one resident (Resident #6), failed to provide an appropriate diagnosis for the use of an antipsychotic (medications used to treat psychosis, a mental health condition characterized by delusions, hallucinations, and disorganized thinking) medication for one resident (Resident #27), and failed to get a physician's response to the GDR recommendation for one resident (Resident #4) out of five sampled residents. The facility census was 50. Review of the facility policy titled, Gradual Dose Reduction of Psychotropic Drugs, dated 10/01/25, showed: - Residents who use psychotropic drugs receive gradual dose reductions and behavioral intervention, unless clinically contraindicated, in an effort to be managed at a lower dose or to discontinue these drugs; - Within the first year in which a resident is admitted on a psychotropic medication, or after the prescribing practitioner has initiated a psychotropic medication, the facility will attempt a GDR according to pharmacy consultant recommendations, unless clinically contraindicated; - After the first year, a GDR will be attempted annually unless clinically contraindicated; - Opportunities during the care process to consider whether the medications should be continued, reduced, discontinued, or otherwise modified include during the monthly medication regimen review by the pharmacist, when the physician or prescribing practitioner evaluates the resident's progress, and during the quarterly Minimum Data Set (MDS &ndash; a federally mandated assessment instrument completed by facility staff) review by the interdisciplinary team. 1. Review of Resident #4's medical record showed: - admission date of 11/06/23; - Diagnoses of unspecified dementia (a cognitive decline such as memory loss, confusion, and communication problems exists, but the underlying cause cannot be clearly identified), major depressive disorder (persistent, severe sadness, low mood, or loss of interest in activities lasting at least two weeks), cognitive communication deficit (problems with communication that have an underlying cause in a cognitive deficit rather than a primary language or speech), and anxiety disorder (excessive, persistent fear or worry that interferes with daily life); - An order for buspirone (an antianxiety medication) 15 milligrams (mg) by mouth three times a day for depression, dated 11/22/25; - An order for duloxetine (an antidepressant medication) 30 mg by mouth one time a day for major depressive disorder, dated 12/02/24; - An order for Rexulti (an antipsychotic (medication used to treat psychosis &ndash; symptoms like hallucinations, delusions, and disorganized thinking) medications) 0.5 mg by mouth one time a day for dementia, dated 01/13/26. (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's monthly medication review showed: - On 02/05/26, the pharmacist recommended the reduction of Rexulti, buspirone, and duloxetine to ensure the resident was using the lowest possible effective/optimal dose; - On 02/11/26, the physician's response showed the request should be sent to psychiatry; - No response from the psychiatrist for the requested GDRs. During an interview on 04/23/26 at 3:30 P.M., the Director of Nursing (DON) said she would expect nurses to make sure the physicians responded to GDR requests. 2. Review of Resident #6's medical record showed: - admission date of 09/03/24; - Diagnoses of adjustment disorder with depressed mood (a short-term mental health condition occurring when intense sadness, hopelessness, and sadness arise in response to a specific life stressor), anxiety disorder, and other amnesia (memory loss); - An order for buspirone 10 mg by mouth two times a day for anxiety, dated 12/10/24; - An order for mirtazapine (an antidepressant medication) 15 mg one tablet by mouth in the evening related to anxiety disorder, dated 11/18/24. Review of the resident's monthly medication reviews showed: - On 05/04/25, the pharmacist recommended the reduction of buspirone or mirtazapine to ensure the resident was using the lowest possible effective/optimal dose; - On 08/01/25, the pharmacist recommended the reduction of buspirone or mirtazapine to ensure the resident was using the lowest possible effective/optimal dose; - No response from the physician noted for the GDR requests for 05/04/25 and 08/01/25; - No GDRs or contraindications documented for buspirone or mirtazapine. During a phone interview on 04/27/26 at 12:30 P.M., the Pharmacy Consultant said the residents' medical records were reviewed monthly and the recommendations were sent to the facility for follow up. 3. Review of Resident #27's medical record showed: - admission date of 01/14/26; - Diagnoses of altered mental status, cerebral infarction (stroke), depression, and ataxia (poor muscle control that causes clumsy movements); - An order for aripiprazole (an antipsychotic medication) 5 mg by mouth one time a day related to (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	altered mental status, dated 01/15/26; - An order for buspirone 5 mg by mouth one time a day related to altered mental status, dated 02/07/26; - An order for mirtazapine 15 mg by mouth at bedtime related to altered mental status, dated 01/14/26; - No monthly medication reviews by pharmacy that addressed an appropriate diagnosis for aripiprazole, buspirone, and mirtazapine. During an interview on 04/28/26 at 1:50 P.M., the Consultant Pharmacist said Resident #27 did not have appropriate diagnosis for aripiprazole, mirtazapine, and buspirone. The diagnosis altered mental status was too vague of a diagnosis even though the resident had a stroke and altered mental status as diagnoses in his/her medical record. e/She would do a recommendation for better diagnoses for the provider to address.		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the resident and/or the resident's representative in writing of a transfer or discharge to a hospital, including the bed hold rates and reason for the transfer, for five residents (Residents #1, #4, #5, #12, and #26) out of 13 sampled residents. The facility's census was 50. The facility did not provide a policy for Transfer/Discharge Notices or Bed Hold Notices. 1. Review of Resident #1's medical record showed:- Transferred to the hospital on [DATE], and readmitted to the facility on [DATE];- Transferred to the hospital on [DATE], and readmitted to the facility on [DATE];- Transferred to the hospital on [DATE], and readmitted to the facility on [DATE];- The reasons for the transfers were not included on the Transfer/Discharge Notices, dated 11/23/25, 12/23/25, and 02/13/26;- The bed hold daily rate was not included on the Bed Hold Notes, dated 11/23/25, 12/23/25, and 02/13/26. 2. Review of Resident #4's medical record showed:- Transferred to the hospital on [DATE], and readmitted to the facility on [DATE];- Transferred to the hospital on [DATE], and readmitted to the facility on [DATE];- Transferred to the hospital on [DATE], and readmitted to the facility on [DATE];- The reasons for the transfers were not included on the Transfer/Discharge Notices, dated 02/03/26, 03/12/26, and 04/10/26;- The bed hold daily rate was not included on the Bed Hold Notes, dated 02/03/26, 03/12/26, and 04/10/26. 3. Review of Resident #5's medical record showed:- Transferred to the hospital on [DATE], and readmitted to the facility on [DATE];- Transferred to the hospital on [DATE], and readmitted to the facility on [DATE];- The reasons for the transfers did not include sufficient reasons for the transfers that could be understood by the resident and/or the resident representative on the Transfer/Discharge Notices, dated 11/26/25 and 04/04/26;- The bed hold daily rate was not included on the Bed Hold Notices, dated 11/26/25 and 04/04/26. 4. Review of Resident #12's medical record showed:- Transferred to the hospital on [DATE], and readmitted to the facility on [DATE];- Transferred to the hospital on [DATE], and readmitted to the facility on [DATE];- No documentation the resident and/or the resident's representative was informed in writing of the transfer/discharge, including the reasons for transfer, to a hospital on [DATE] and 04/12/26;- The bed hold daily rate was not included on the Bed Hold Notice, dated 03/21/26. 5. Review of Resident #26's medical record showed:- Transferred to the hospital on [DATE], and readmitted to the facility on [DATE];- The reason for transfer was not included on the Transfer/Discharge Notice, dated 03/18/26;- The bed hold daily rate was not included on the Bed Hold Notice, dated 03/18/26. During an interview on 04/22/26 at 1:55 P.M., Licensed Practical Nurse (LPN) G said he/she printed and filled out the Transfer/Discharge Notice when a resident was sent to the hospital, but he/she did not give a copy of the Bed Hold Notice. During an interview on 04/22/26 at 2:00 P.M., LPN A said that he/she filled out the Transfer/Discharge Notice when a resident was sent to the hospital, but that he/she had never heard of a Bed Hold Notice. During an interview on 04/23/26 at 12:22 P.M., the Regional Quality Assurance Nurse said residents' representatives were notified by phone of the resident's transfer to the hospital. She said the Bed Hold Notice was mailed to the resident's responsible party. During an interview on 04/23/26 at 1:45 P.M., the Social Services Designee (SSD) said nurses filled out the Transfer/Discharge Notice, and that she filled out the Bed Hold Notice and either gave both forms to the resident or mailed them to the resident's responsible party. She said residents were informed at the time of admission of the Bed Hold rate. During an interview on 04/23/26 at 4:05 P.M., the Administrator and the Director of Nursing (DON) said they would expect the resident and their representative to be informed in writing, and in a language they understood, of a resident's transfer to the hospital. They would also expect the resident or their representative to be informed of the Bed Hold Notice, including the daily rate, when a resident was transferred to the hospital.		

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition Based on interview and record review, the facility failed to complete a significant change Minimum Data Set (MDS - a federally mandated assessment instrument to be completed by facility staff) assessment within 14 days of a resident admitted to hospice. This affected one resident (Resident #22) out of two sampled residents. The facility census was 50. Review of the MDS 3.0 Resident Assessment Instrument (RAI) Users Manual, Chapter 5: Submission and Correction of the MDS Assessment, dated October 2025, showed:- Completion timing for Significant Change in Status Assessment, the Care Area Assessment (CAA) completion date must be no later than 14 days from the Assessment Reference Date (ARD) and no later than 14 days from the determination date of the significant change in status. The facility did not provide a policy regarding MDS Submission Timeframes. 1. Review of Resident #22's medical record showed:- An admission date of 09/09/24;- admitted to hospice on 10/21/25;- No significant change MDS dated on or after 10/21/25;- The facility failed to complete a significant change MDS within 14 days of admission to hospice. During an interview on 04/23/26 at 12:46 P.M., the MDS Coordinator said she started this position in November and then went on medical leave almost immediately after starting. Therefore, she has not completed her MDS training. She said a significant change MDS should be completed seven days after a resident's admission to hospice. During an interview on 04/23/26 at 1:30 P.M., the Director of Nursing (DON) said the facility did not have an on-site MDS Coordinator for several months and a nurse had helped fill in while the MDS Coordinator was on medical leave. She would expect a significant change MDS to be completed in the appropriate timeframe. During an interview on 04/23/26 at 3:50 P.M., the Administrator said he would expect a significant change MDS to be completed in the appropriate timeframe.		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to obtain an order for a urinary catheter (a sterile tube inserted into the bladder to drain urine) and failed to provide a diagnosis for the use of a urinary catheter for two residents (Residents #33 and #44) out of two sampled residents. The facility census was 50. Review of the facility's policy titled, Indwelling Catheter Use and Removal, implemented on 10/01/25, showed: - It is the policy of this facility to ensure that indwelling urinary catheters that are inserted or remain in place are justified or removed according to regulations and current standards of practice; - A resident will not be catheterized unless the resident's clinical condition demonstrates that catheterization is necessary; - If an indwelling catheter is in use, the facility will provide appropriate care for the catheter in accordance with current professional standards of practice and resident care policies and procedures that include documentation of the involvement of the resident representative in the discussion of the risks and benefits of the use of the catheter, removal of the catheter when criteria or indication for use is no longer present, timely and appropriate assessments related to the indication for use of an indwelling catheter, identification and documentation of clinical indications for the use of the catheter, insertion, ongoing care and catheter removal protocols, response of the resident during the use of the catheter, and ongoing monitoring for changes in condition related to potential catheter-associated urinary tract infections; - Appropriate indications for indwelling catheter use include acute urinary retention or bladder obstruction, need for accurate measurements of urinary output, assistance in healing of open sacral (triangular bone above the coccyx) or perineal wounds in incontinent residents, residents that require prolong immobilization, and to improve comfort for end-of-life care if needed. 1. Review of Resident #33's medical record showed: - admitted on [DATE]; - admitted to the hospital on [DATE], and returned to the facility on [DATE], with a urinary catheter; - No diagnosis for a urinary catheter; - No physician order for the urinary catheter; - The facility failed to obtain a diagnosis and a physician order for the urinary catheter. Review of the resident's care plan, undated, showed: - Did not address the urinary catheter with individualized goals and interventions. Observation of the resident on 04/20/26 at 10:38 A.M., showed: (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The resident lay in the bed with a urinary catheter. During an interview on 04/20/26 12:15 P.M., the resident's representative said he/she was unsure why the resident had a urinary catheter. 2. Review of Resident #44's medical record showed: - An admission date of 03/27/26; - No physician order for a urinary catheter; - An order to monitor urine output collected in the urinary catheter every shift, dated 03/30/26; - No diagnosis for the urinary catheter; - The facility failed to obtain a diagnosis and an order for the urinary catheter. Review of the resident's care plan, dated 04/23/26, showed: - Did not address the urinary catheter with individualized goals and interventions. Observation of the resident on 04/20/26 at 3:06 P.M., showed: - The resident lay in bed with a urinary catheter. During an interview on 04/21/26 at 9:12 A.M., the resident said he/she was unsure of the reason for the urinary catheter. During an interview on 04/23/26 at 10:05 A.M., Licensed Practical Nurse (LPN) A said residents with urinary catheters should have an order and a diagnosis for the urinary catheter. During an interview on 04/23/26 at 10:37 A.M., the Director of Nursing (DON) said residents with urinary catheters should have an order and a diagnosis for the urinary catheter.		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide documentation of a physician's order and on-going assessments and monitoring after dialysis (a process for removing waste and excess water from the blood) for one resident (Resident #8) out of one sampled resident. The facility's census was 50. Review of the facility's policy titled, Dialysis, approved 01/30/24, showed:- 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;- The facility will ensure appropriate monitoring of the dialysis resident's status before, during, and after the treatments;- 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. 1. Review of Resident #8's physician's order sheet (POS), dated April 2026, showed:- admitted on [DATE];- Diagnosis of ESRD;- No order for dialysis;- No order to assess the dialysis site and/or dressing before and after dialysis;- No order for vital signs before and after dialysis. Review of the resident's annual Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 03/04/26, showed:- The resident received dialysis. Review of the resident's care plan, undated, showed:- At risk of complications due to receiving dialysis with interventions of assess the thrill (a palpable vibration felt on the skin over a dialysis access site) and bruit (the swooshing sound heard with a stethoscope over a dialysis access site) as ordered, assess vital signs and weight before and after dialysis and record, and monitor dialysis port access and ensure dressing is clean, dry and intact;- Dependent on dialysis due to ESRD, dialysis days Tuesday, Thursdays, and Fridays, with interventions to assess vital signs and weight before and after dialysis appointments, monitor the dialysis port (dialysis access site) in the chest to ensure the dressing is clean dry and intact, monitor the dialysis fistula (a surgically created connection between an artery and a vein for dialysis use) in the left arm for the thrill and bruit. Review of the resident's Dialysis Communication Reports, dated 03/03/26 - 04/21/26, showed:- Six out of 23 opportunities missed for the assessment of the dialysis site/dressing before dialysis;- 20 out of 23 opportunities missed for the vital signs, weights, and assessment of the dialysis site/dressing after dialysis. During an interview on 04/20/25 at 10:46 A.M., the resident said he/she went to dialysis on Tuesdays, Thursdays, and Saturdays, had a port on the right side of his/her chest, and an access in the left arm. Staff did look at the port and the access sometimes, and took his/her vital signs sometimes, just not always on dialysis days. During an interview on 04/23/26 at 10:05 A.M., Licensed Practical Nurse (LPN) A said residents that went to dialysis should have an order for dialysis and to assess the dialysis access site or sites. Vital signs and weights before and after dialysis were documented on the dialysis communication form. During an interview on 04/23/26 at 10:35 A.M., the Director of Nursing (DON) said residents who went to dialysis should have an order for dialysis and an order to monitor the dialysis access site. The nurses were to document the dialysis resident's vital signs, weights, and access assessments on the dialysis communication forms before and after each dialysis treatment.		

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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)		
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, the facility failed to implement procedures to ensure medications were accurately documented and reconciled for one resident (Resident #21) out of five sampled residents. The facility census was 50. Review of the facility policy titled, Controlled Substance Administration and Accountability, dated 10/01/25, showed:- All controlled substances obtained from a non-automated medication cart or cabinet are recorded on the designated usage form. Written documentation must be clearly legible with all applicable information provided;- All specially compounded or non-stock Schedule II controlled substances dispensed from the pharmacy for a specific patient are recorded on the Controlled Drug Record supplied with the medication or other designated form as per facility policy;- In all cases, the dose noted on the usage form or entered into the automated dispensing system must match the dose recorded on the Medication Administration Record (MAR), Controlled Drug Record, or other facility specified form and placed in the patient's medical record;- The Controlled Drug Record (or other specified form) serves the dual purpose of recording both narcotic disposition and patient administration;- The Controlled Drug Record is a permanent medical record document and in conjunction with the MAR is the source for documenting any patient-specific narcotic dispensed from the pharmacy;- The charge nurse or other designee conducts a daily visual audit of the required documentation of controlled substances;- Any discrepancy in the count of controlled substances or disposition of the narcotic keys is resolved by the end of the shift during which it is discovered;- Resolution can be achieved by review of dispensing and administration records and consulting with all staff with access;- Staff may not leave area until discrepancies are resolved or reported as unresolved discrepancies. 1. Review of Resident #21's April 2026 physician order sheet (POS) showed:- An order for morphine (narcotic pain medication used for moderate to severe pain) 20 milligram/1 milliliter (ml) 0.25 ml sublingually (administer under the tongue) every one hour as needed for pain, dated 05/16/25. Review of the resident's Narcotic Record for morphine 100 mg/5 ml 30 ml bottle on 04/22/26 at 11:11 A.M., showed:- On 04/21/26 at 6:30 A.M., Licensed Practical Nurse (LPN) A administered 0.25 ml of the resident's morphine with 7.25 ml remaining in the bottle. Observation on 04/22/26 at 11:11 A.M., of the nurse's narcotic medication cart showed:- One opened and undated with an unreadable label of the resident's 30 ml bottle of morphine 100 mg/5 ml with approximately 5 ml remaining in the bottle. During an interview on 04/22/26 at 11:11 A.M., LPN A said it looked like at least four doses of the resident's morphine 100 mg/5 ml were documented in the resident's medication administration record (MAR) as administered for April that were not documented on the resident's Narcotic Record. He/She did not know of any missing medication doses or discrepancies of the resident's morphine. He/She would expect the Narcotic Record to match the MAR. During an interview on 04/22/26 at 11:20 A.M., the Regional Nurse and the Director of Nursing (DON) said they would expect the Narcotic Record to align with the MAR. The nurses should document and look at the medication amount when doing the medication check off and count each time to ensure accuracy of the count. If there was a discrepancy found, staff should let the DON know. Correct math should be done when tracking the medication usage on the Narcotic Record as there was at least one time found where the remaining amount in the bottle was written incorrectly. During an interview on 04/22/26 at 11:30 A.M., LPN G said he/she was the last person to count the cart this morning and did not notice the discrepancies of the amounts between the Narcotic Record sheet amount of 7.25 ml and the bottle amount of approximately 5 ml. No one had been in the cart since he/she counted that morning that he/she knew of, and he/she had not given the morphine to the resident today. He/She would expect the Narcotic Record to match the amount in the bottle. The narcotic cart was counted at the end of each shift with the oncoming nurse and both nurses signed that it was counted. If there was a discrepancy, then the nurses could not leave until the DON was aware and the discrepancy was resolved.		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility failed to maintain an error rate of less than five percent (%) when medications were administered. There were 34 opportunities with six errors made, for an error rate of 17.6% which affected three residents (Residents #12, #29, and #32) out of four sampled residents. The facility census was 50. The facility did not provide a policy for insulin administration. Review of the Humalog/insulin lispro (a rapid-acting insulin) and NovoLog/insulin aspart (a rapid-acting insulin) Pen's Manufacturer Guidelines for Priming Before Each Injection and Administration, revised 02/2023, showed:- Turn the dose selector to select two units;- Hold the pen with the needle pointing up;- Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge;- Keep the needle pointing upwards, press the push-button all the way in;- The dose selector returns to zero;- A drop of insulin should appear at the needle tip. If not, change the needle and repeat the procedure no more than six times. 1. Review of Resident #12's medical record showed:- Diagnosis of diabetes mellitus (DM - a metabolic disease) with diabetic peripheral angiopathy (narrowing or blockage of blood vessels outside of heart);- An order for Humalog insulin pen inject as per sliding scale for blood sugar of 60 - 149 = 0 units, 2-10 units per sliding scale subcutaneously (beneath the skin) four times a day. Less than 60 = Glucagon (medication to raise blood sugar) 1 milligram (mg) intramuscular (IM - administered into the muscle) and call the physician, for 150 - 200 = 2 units, 201 - 250 = 4 units, 251 - 300 = 6 units, 301 - 350 = 8 units, and 351 - 400 = 10 units subcutaneously four times a day related to DM with diabetic peripheral angiopathy, dated 03/26/26;- An order to prime the insulin pen with 2 units before use with meals related to DM with diabetic peripheral angiopathy, with no order date. Review of the resident's April 2026 medication administration record (MAR) showed:- Did not receive a blood sugar check and did not receive insulin as ordered prior to the lunch meal on 04/21/26. 2. Review of Resident #29's medical record showed:- Diagnosis of DM;- An order for Novolog insulin pen inject as per sliding scale for blood sugar of 1 - 150 = 0 units, 151 - 200 = 2 units, 201 - 250 = 4 units, 251 - 300 = 6 units, 301 - 350 = 8 units, 351 - 400 = 10 units, 401 - 450 = 12 units subcutaneously four times a day for DM, dated 01/08/26; Review of the resident's April 2026 MAR showed:- Did not receive a blood sugar check and did not receive insulin as ordered prior to the lunch meal on 04/21/26. Observation on 04/22/26 at 11:45 A.M., of the resident's insulin administration showed:- Licensed Practical Nurse (LPN) A did not prime the resident's Novolog insulin pen;- LPN A administered 12 units of Novolog to the resident for a blood sugar of 515. During an interview on 04/22/26 at 11:46 A.M. LPN A said an insulin pen did not require anything to be done to it before dialing up the insulin dose for administration. He/She did not have time to do blood sugar checks and administer the insulin doses on 04/21/26 for the lunch meal for Residents #12 and #29 as ordered. He/She notified other staff of not having time to do the residents' blood sugars and insulin administration, but no one completed the tasks. He/She talked to the Director of Nursing (DON) and she said the residents were already eating or so the blood sugars and insulin should be held at that time. LPN A notified the physician later and was told to their check blood sugars at the next scheduled time and if there were any issues to call back. 3. Review of Resident # 32's medical record showed:- Diagnosis of DM with diabetic polyneuropathy (nerve or sensation issues);- An order for insulin lispro pen inject as per sliding scale for blood sugar of 0 - 150 = 0 units, 151 - 200 = 1 unit, 201 - 250 = 2 units, 251 - 300 = 3 units, 301 - 350 = 4 units, 351 - 400 = 5 units, 401 - 500 = 6 units. If over 400, give 6 units, then call the physician, subcutaneously four times a day related to DM with diabetic polyneuropathy, with no order date;- An order to prime the insulin pen with 2 units before use before meals and at bedtime related to DM with diabetic polyneuropathy, with no order date. Observation on 04/21/26 at 11:46 A.M., of Resident #32's insulin administration showed:- LPN B did not prime the insulin pen;- LPN B administered 4 units of insulin lispro to the resident for a blood sugar of 336. During an interview on 04/21/26 at 11:48 A.M., LPN B said he/she did not need to do anything before dialing up the dose on the insulin pen before administration. During (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	an interview on 04/23/26 at 4:00 P.M., the DON and the Administrator said they would expect the medication error rate to be less than five percent. They would expect medications to be given as ordered and for insulin pens to be primed with two units before administration.		

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observation, interview, and record review, the facility failed to ensure drugs and biologicals were labeled in accordance with currently accepted practices, failed to store medications in a safe and effective manner when staff left the medication refrigerator narcotic medication behind only one lock, and failed to check and maintain a daily refrigerator temperature log. This had the potential to affect all residents. The facility census was 50. Review of the facility policy titled, Labeling of Medications and Biologicals, dated 10/01/25, showed:- Medication labels must be legible at all times;- Any medication label that is soiled, incomplete, illegible, worn, or makeshift must be returned and replaced by the issuing pharmacy, not merely covered;- Labels for multi-use vials must include the date the vial was initially opened or accessed (needle-punctured), all opened or accessed vials should be discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial, and unopened or unaccessed vials should be discarded according to the manufacturer's expiration date. Review of the facility policy titled, Controlled Substance Administration and Accountability, dated 10/01/25, showed:- Areas without automated dispensing systems utilize a substantially constructed storage unit with two locks and a paper system for 24-hour recording of controlled substance use;- Resident specific controlled substances are stored under double lock until administered to the resident. 1. Observation of the medication storage room on 04/22/26 at 10:55 A.M., showed:- The lock box in the medication refrigerator unlocked with three 30 milliliters (ml) bottles of lorazepam (an antianxiety medication) 2 milligrams (mg)/ml with two of the three bottles opened and undated;- Four opened and undated 5 ml tuberculin (used to diagnosis tuberculosis (TB - infectious disease caused by the tubercle bacillus)) vials. Review of the temperature log for the medication refrigerator from February 2026 - April 2026 showed:- February temperatures not checked on 02/01/26, 02/06/26 - 02/08/26, 02/15/26, 02/19/26, and 02/24/26 - 02/27/26 for a total of 10 out of 28 opportunities missed;- March temperatures not checked on 03/09/26 - 03/11/26, and 03/16/26 - 03/31/26 for a total of 19 out of 31 opportunities missed;- April temperatures not checked on 04/01/26 - 04/03/26, 04/16/26, and 04/17/26 for a total of five out of 22 opportunities missed. 2. Observation on 04/22/26 at 11:11 A.M., of the nurse's narcotic medication cart showed:- One opened and undated with an unreadable label bottle of morphine (narcotic pain medication used for moderate to severe pain) 100 mg/5 ml. During an interview on 04/22/26 at 11:30 A.M., Licensed Practical Nurse (LPN) G said the refrigerator temperatures were done daily on the night shift. The narcotic medication in the lock box kept in the refrigerator should be locked at all times. He/She did not know about checking the medication carts for expired medications or other issues and should ask the Director of Nursing (DON). Medications should be labeled with the date and the staff's initials when opened. During an interview on 04/23/26 at 4:00 P.M., the DON said she would expect narcotic medications to be stored behind two locked devices. Pharmacy rounded monthly to check for expired medications. She would expect multidose medication vials to be labeled with a date and initials when opened. The refrigerator temperatures should be done at least daily.		