STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265550	A. Building B. Wing	11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire Senior Living Advance	315 South Tilley Street Advance, MO 63730

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 0575 Level of Harm - Potential for minimal harm Residents Affected - Many	Post a list of names, addresses, and telephone numbers of all pertinent State agencies and advocacy groups and a statement that the resident may file a complaint with the State Survey Agency. 47678 Based on observation, interview, and record review, facility staff failed to post, in a form and manner accessible to the residents and resident representatives, the required telephone number to the Department of Health and Senior Services (DHSS) hotline (to report allegations of abuse and neglect), or a list of names, addresses, and phone numbers of the State Survey Agency (SSA). The census was 34. The facility did not provide a policy. Observation of the facility on 11/19/24 through 11/21/24, showed the facility did not post the name, address and toll free telephone number for the DHSS Abuse and Neglect Hotline or the SSA information in a form and manner accessible to residents or visitors. During a group interview on 11/21/24 at 9:35 A.M., six residents (Residents #3, #6, #8, #20, #21, and #237) said they did not how to find the state hotline number and had not seen it posted. During an interview on 11/21/24 at 9:49 A.M., Licensed Practical Nurse (LPN) E said if a resident wanted the state hotline number, he/she could look it up for them. During an interview on 11/21/24 at 9:51 A.M., Certified Nursing Assistant (CNA) G said he/she did not know if the abuse and neglect hotline number was posted anywhere. During an interview on 11/21/24 at 9:55 A.M., the Social Services Designee (SSD) said residents were given the DHSS hotline number when they were admitted and thought the number was on the resident rights poster. During an interview on 11/21/24 at 9:58 A.M., the Administrator said the DHSS Abuse and Neglect Hotline number should be posted.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265550	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/22/2024
NAME OF PROVIDER OR SUPPLIER Aspire Senior Living Advance		STREET ADDRESS, CITY, STATE, ZIP CODE 315 South Tilley Street Advance, MO 63730	

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47447 Based on interview and record review, the facility failed to notify the resident and/or the resident's representative in writing of a transfer/discharge to a hospital, including the reasons for transfer, for three residents (Residents #1, #28 and #32) out of 12 sampled residents. The facility's census was 34. Review of the facility's policy titled, Discharge-Transfer of Resident, dated 03/2015, showed: - Explain transfer and reason to the resident and/or representative and give copy of signed transfer or discharge notice to the resident and/or representative or person responsible for care. If an emergency transfer, transfer or discharge notice form may be completed later, but as soon as possible. 1. Review of Resident #1's medical record showed: - The resident transferred to the hospital on 02/28/24, and readmitted to the facility on [DATE]; - The resident transferred to the hospital on 03/14/24, and readmitted to the facility on [DATE]; - The resident transferred to the hospital on 04/13/24, and readmitted to the facility on [DATE]; - The resident transferred to the hospital on 04/27/24, and readmitted to the facility on [DATE]; - The resident transferred to the hospital on 05/06/24, and readmitted to the facility on [DATE]; - The resident transferred to the hospital on 06/17/24, and readmitted to the facility on [DATE]; - The resident transferred to the hospital on 07/20/24, and readmitted to the facility on [DATE]; - No documentation the resident or resident representative was informed in writing of the transfer/discharge to a hospital at the time of the the transfers. 2. Review of Resident #28's medical record showed: - The resident transferred to the hospital on 01/27/24, and readmitted to the facility on [DATE]; - No documentation the resident or resident representative was informed in writing of the transfer/discharge to a hospital at the time of the transfer. 3. Review of Resident #32's medical record showed: - The resident transferred to the hospital on 04/12/24, and readmitted to the facility on [DATE]; - The resident transferred to the hospital on 05/02/24, and readmitted to the facility on [DATE]; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265550	A. Building B. Wing	11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire Senior Living Advance	315 South Tilley Street Advance, MO 63730

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The resident transferred to the hospital on 05/15/24, and readmitted to the facility on [DATE]; - The resident transferred to the hospital on 06/20/24, and readmitted to the facility on [DATE]; - No documentation the resident or resident representative was informed in writing of the transfer/discharge to a hospital at the time of the transfers. During an interview on 11/22/24 at 1:05 P.M., the Social Services Director (SSD) said he/she would fill out the transfer/discharge paperwork but not give it to the resident until he/she knew the resident would be admitted to the hospital. He/She would leave the paperwork in the resident's room for them for when the resident returned. During an interview on 11/22/24 at 3:18 P.M., the Administrator said she expected the notice of a resident's transfer to the hospital to be given to the resident and/or their representative in writing. 49152

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265550	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire Senior Living Advance	315 South Tilley Street Advance, MO 63730

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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident’s representative in writing how long the nursing home will hold the resident’s bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47447 Based on interview and record review, the facility failed to inform the resident and/or the legal representative of their bed hold policy at the time of transfer to the hospital for three residents (Residents #1, #28 and #32) out of 12 sampled residents. The facility's census was 34. Review of the facility's policy titled, Bed Hold, undated, showed: - The facility will notify the resident at the time of admission and again prior to a hospital transfer or therapeutic leave of its bed-hold and return policies; - Before any transfer, advance notice of the policy is given, usually at the time of admission and also included in the admission packet. Re-issuance of the first notice is not required unless the facility's policy changes; - In cases of emergency transfer, notice at the time of transfer means that the resident, family, or representative is provided with written notification within 24 hours of the transfer. 1. Review of Resident #1's medical record showed: - The resident transferred to the hospital on 02/28/24, and readmitted to the facility on [DATE]; - The resident transferred to the hospital on 03/14/24, and readmitted to the facility on [DATE]; - The resident transferred to the hospital on 04/13/24, and readmitted to the facility on [DATE]; - The resident transferred to the hospital on 04/27/24, and readmitted to the facility on [DATE]; - The resident transferred to the hospital on 05/06/24, and readmitted to the facility on [DATE]; - The resident transferred to the hospital on 06/17/24, and readmitted to the facility on [DATE]; - The resident transferred to the hospital on 07/20/24, and readmitted to the facility on [DATE]; - No documentation the resident or resident representative was informed in writing of the facility bed hold policy at the time of the transfers. 2. Review of Resident #28's medical record showed: - The resident transferred to the hospital on 01/27/24, and readmitted to the facility on [DATE]; - No documentation the resident or resident representative was informed in writing of the facility bed hold policy at the time of the transfer. 3. Review of Resident #32's medical record showed: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265550	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/22/2024
NAME OF PROVIDER OR SUPPLIER Aspire Senior Living Advance		STREET ADDRESS, CITY, STATE, ZIP CODE 315 South Tilley Street Advance, MO 63730	

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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The resident transferred to the hospital on 04/12/24, and readmitted to the facility on [DATE]; - The resident transferred to the hospital on 05/02/24, and readmitted to the facility on [DATE]; - The resident transferred to the hospital on 05/15/24, and readmitted to the facility on [DATE]; - The resident transferred to the hospital on 06/20/24, and readmitted to the facility on [DATE]; - No documentation the resident or resident representative was informed in writing of the facility bed hold policy at the time of the transfers. During an interview on 11/22/24 at 1:05 P.M., the Social Services Director (SSD) said he/she would fill out the facility bed hold policy paperwork but not give it to the resident until he/she knew the resident would be admitted to the hospital. He/She would leave the paperwork in the resident's room for them for when the resident returned. During an interview on 11/22/24 at 3: 19 P.M., the Administrator said she expected the bed hold notice to be given to the resident and/or their representative at the time of the resident's transfer to the hospital. 49152

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265550	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/22/2024
NAME OF PROVIDER OR SUPPLIER Aspire Senior Living Advance		STREET ADDRESS, CITY, STATE, ZIP CODE 315 South Tilley Street Advance, MO 63730	

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47447 Based on interview and record review, the facility failed to accurately code the Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, for three residents (Residents #6, #11, and #32) out of 12 sampled residents. The facility census was 34. The facility did not provide a policy regarding MDS accuracy. 1. Review of Resident #6's medical record showed: - An admitted [DATE]; - Diagnoses of hypertension (high blood pressure), diabetes mellitus (DM - a condition that affects the way the body processes blood sugar), convulsions (seizures - a burst of uncontrolled electrical activity between brain cells that causes temporary abnormalities in muscle tone or movements like stiffness, twitching or limpness, behaviors, sensations, or states of awareness), and hypothyroidism (abnormal thyroid producing wrong amount of hormones); - An order for lisinopril (blood pressure medication) 20 milligrams (mg) oral once a day for essential hypertension, dated 08/21/24; - An order for labetalol (blood pressure medication)100 mg oral twice a day for essential hypertension, dated 08/21/24; - An order for Jardiance (used for abnormal glucose levels)10 mg oral once a day for type 2 DM, dated 08/21/24; - An order for Cardizem (blood pressure medication)120 mg extended release 24 hour oral once a day for essential hypertension, dated 08/21/24; - An order for levothyroxine (thyroid medication) 50 micrograms (mcg) oral once a day for hypothyroidism, dated 08/21/24; Review of the resident's admission MDS, dated [DATE], showed: - Hypertension, hypothyroidism, and seizure disorder diagnoses not documented; - Hypoglycemic medication not documented. 2. Review of Resident #11's medical record showed: - An admitted [DATE]; - An order to discontinue Eliquis (an anticoagulant medication), dated 07/09/24; - No current order for an anticoagulant medication. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265550	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/22/2024
NAME OF PROVIDER OR SUPPLIER Aspire Senior Living Advance		STREET ADDRESS, CITY, STATE, ZIP CODE 315 South Tilley Street Advance, MO 63730	

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #11's quarterly MDS, dated [DATE], showed: - The resident received an anticoagulant. 3. Review of Resident #32's medical record showed: - An admitted [DATE]; - Diagnoses of cerebral infarction (stroke), hemiplegia and hemiparesis (paralysis affecting one side of the body) of left side, gastroesophageal reflux disease (GERD - stomach acid being forced back into the throat region), and venous thrombosis/embolism (blood clot); - A fall on 09/12/24; - An order for pantoprazole (helps protect the stomach from ulcers and indigestion) 40 mg oral once a day for GERD, dated 05/18/24; - An order for Eliquis 5 mg tablet oral two times a day for hemiplegia and hemiparesis following cerebral infarction, dated 05/19/24. Review of the resident's annual MDS, dated [DATE], showed: - GERD and cerebral infarction diagnoses not documented; - The fall on 09/12/24, not documented. During an interview on 11/22/24 at 3:25 P.M., the Administrator said she expected the MDS to accurately reflect the resident's current condition. During an interview on 11/22/24 at 3:35 P.M., the MDS Coordinator said he/she would expect the MDS to accurately reflect the resident's current condition. 49152

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265550	A. Building B. Wing	11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire Senior Living Advance	315 South Tilley Street Advance, MO 63730

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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47447 Based on observation, interview and record review, the facility failed to appropriately assess the use of bed rails for four residents (Residents #1, #2, #7 and #28) out of 10 sampled residents and one resident (Resident #3) outside the sample. The facility census was 34. The facility did not provide a policy regarding bed rails. 1. Review of Resident #1's quarterly Minimum Data Set (MDS - a federally mandated assessment completed by the facility), dated 11/01/24, showed: - Cognitively intact; - Required supervision with bed mobility; - The MDS did not indicate bed rail use. Review of the resident's care plan, revised 11/05/24, showed: - A risk of falls; - Addressed the resident's use of the bed rails. Review of the resident's medical record showed: - No documentation of bed rail assessments; - No documentation of informed consent for the use of the bed rails explaining the risks and benefits. Observation of the resident on 11/20/24 at 2:25 P.M., showed the resident lay in bed with 1/4 bed rails on both sides of the bed in the upright position. During an interview on 11/20/24 at 2:30 P.M., Resident #1 said he/she used the bed rails to turn and reposition in bed. 2. Review of Resident #2's quarterly MDS, dated [DATE], showed: - Cognitively intact; - Independent with bed mobility; - Diagnoses of dementia (the impaired ability to remember, think, or make decisions that interferes with doing everyday activities), pain, and repeated falls. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265550	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/22/2024
NAME OF PROVIDER OR SUPPLIER: Aspire Senior Living Advance		STREET ADDRESS, CITY, STATE, ZIP CODE: 315 South Tilley Street Advance, MO 63730	

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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's care plan, revised 10/31/24, showed: - A risk of falls; - Did not address the resident's use of the bed rails. Review of the resident's medical record showed: - No documentation of bed rail assessments; - No documentation of informed consent for the use of the bed rails explaining the risks and benefits. Observations on 11/19/24 at 8:53 A.M., and 11/21/24 at 12:26 P.M., showed: - The resident lay in bed with U shaped bed rails on both sides of the bed in the upright position. During on an interview on 11/21/24 at 12:27 P.M., Resident #2 said he/she used the left bed rail to get out of bed. 3. Review of Resident #3's quarterly MDS, dated [DATE], showed: - Cognition intact; - Roll in bed needed partial to moderate assistance, sit to lying needed substantial assistance, and dependent on staff for other bed mobility; - Diagnosis of left below the knee amputation; - The MDS did not indicate bed rail use. Review of the resident's care plan, revised 11/12/24, showed: - At risk for falls due to mobility issues; - Assistance with one or two staff with bed mobility due to the left below the knee amputation; - Have a halo bar (type of bed rail) on the bed to help with mobility. Review of the resident's medical record showed: - No documentation of bed rail assessments; - No documentation of informed consent for the use of the bed rails explaining the risks and benefits. Observations of the resident showed: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265550	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/22/2024
NAME OF PROVIDER OR SUPPLIER: Aspire Senior Living Advance		STREET ADDRESS, CITY, STATE, ZIP CODE: 315 South Tilley Street Advance, MO 63730	

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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 11/19/24 at 9:45 A.M., the resident sat in a chair next to the bed with the upper left 1/4 square-shaped bed rail attached in the upright position; - On 11/21/24 at 2:25 P.M., the resident lay in bed with the upper left 1/4 square-shaped bed rail attached in the upright position. During an interview on 11/20/24 at 2:56 P.M., Resident #3 said he/she used the bed rail all the time to position him/herself in bed. 4. Review of Resident #7's medical record showed: - admitted on [DATE]; - An order for bed rails, dated 03/24/23; - No documentation of bed rail assessments; - No documentation of informed consent for the use of the bed rails explaining the risks and benefits. Review of the resident's significant MDS, dated [DATE], showed: - Cognition intact; - Did not use bed rails. Review of the resident's care plan, revised on 11/12/24, showed: - At risk for falls; - Required significant assistance with activities of daily living (ADLs); - Required a bed rail to promote independence with bed mobility. Observation on 11/21/24 at 11:21 A.M., showed the resident lay in bed with the upper 1/4 bed rails on both sides of the bed in the upright position. 5. Review of Resident #28's quarterly MDS, dated [DATE], showed: - Cognition intact; - Dependent with bed mobility; - Diagnoses of stroke (damage to the brain from interrupted blood supply), hemiplegia and hemiparesis (paralysis or inability to move one side of body) affecting left side, pain, morbid obesity (overweight), weakness. Review of the resident's medical record showed: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265550	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/22/2024
NAME OF PROVIDER OR SUPPLIER: Aspire Senior Living Advance		STREET ADDRESS, CITY, STATE, ZIP CODE: 315 South Tilley Street Advance, MO 63730	

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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- No documentation of bed rail assessments; - No documentation of informed consent for the use of the bed rails explaining the risks and benefits. Review of the resident's care plan, revised 11/07/24, showed: - At risk of falls due to limited mobility;. - Had grab bars on the bed to assist with independence in bed mobility. Observations on 11/19/24 at 9:45 A.M and 11/22/24 at 2:45 P.M., showed the resident lay in bed with the upper 1/4 circular-shaped bed rails on both sides of the bed in the upright position. During an interview on 11/22/24 at 3:10 P.M., the Director of Nursing (DON) said she would expect residents with any bed rails to have an assessment for use of the bed rails and informed consents. During an interview on 11/22/24 at 3:10 P.M., the Administrator said she would expect residents with any bed rails to have an assessment for use of the bed rails and informed consents. 47678 49152 49999

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265550	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/22/2024
NAME OF PROVIDER OR SUPPLIER: Aspire Senior Living Advance		STREET ADDRESS, CITY, STATE, ZIP CODE: 315 South Tilley Street Advance, MO 63730	

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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47447 Based on observation, interview, and record review, the facility failed to ensure residents diagnosed with dementia (a decline in memory or other thinking skills severe enough to reduce a person's ability to perform everyday activities) had a personalized plan of care to ensure appropriate services to promote the resident's highest level of functioning and psychosocial needs were provided for one resident (Residents #9) out of three sampled residents. The facility census was 34. The facility did not provide a policy regarding dementia care. 1. Review of Resident #9's medical record showed: - An admitted [DATE]; - Diagnoses of unspecified dementia (a condition characterized by progressive or persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking) and cognitive communication deficit (difficulty communicating). Review of the resident's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by the facility staff, dated 09/16/24, showed: - Able to understand others and to be understood; - Diagnosis of dementia. Review of the resident's care plan, dated 09/22/24, showed: - Did not address dementia; - Did not address specific problems, interventions, or goals for dementia care; - Did not address specific problems, interventions, or goals for activities for a resident diagnosed with dementia. Observations of the resident showed: - On 11/21/24 at 11:10 A.M., the resident self propelled wheelchair around dining room and nurse's station; - On 11/22/24 at 9:05 A.M., the resident sat in the wheelchair in the dining room. During an interview on 11/22/24 at 3:10 P.M., the Director of Nursing (DON) and the Administrator said dementia should be addressed on the care plan. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265550	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/22/2024
NAME OF PROVIDER OR SUPPLIER Aspire Senior Living Advance		STREET ADDRESS, CITY, STATE, ZIP CODE 315 South Tilley Street Advance, MO 63730	

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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/22/24 at 3:20 P.M., the MDS coordinator said dementia should be addressed on the care plan. 47678

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265550	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/22/2024
NAME OF PROVIDER OR SUPPLIER: Aspire Senior Living Advance		STREET ADDRESS, CITY, STATE, ZIP CODE: 315 South Tilley Street Advance, MO 63730	

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47447 Based on interview and record review, the facility failed to ensure an appropriate diagnosis for the use of a psychotropic (a drug that affects the brain activities associated with mental processes and behavior) medication for two residents (Residents #9 and #11) out of 12 sampled residents and one resident (Resident #15) outside the sample. The facility census was 34. The facility did not provide a policy regarding appropriate diagnosis of a psychotropic medication. Review of AstraZeneca's Product Monograph for quetiapine, revised 11/29/21, showed: - Quetiapine is indicated for schizophrenia (a long term mental disorder that affects a person's ability to think, feel, or behave clearly, sometimes including delusions or hallucinations) and bipolar disorder (a mental disorder that causes unusual shifts in mood); - Quetiapine is not indicated in elderly patients with dementia (a condition characterized by progressive or persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking); - Elderly patients with dementia treated with atypical antipsychotic (a drug that affects the brain activities associated with mental processes and behavior) drugs are at an increased risk of death compared to placebo. 1. Review of Resident #9's medical record showed: - An admitted [DATE]; - Diagnoses of unspecified dementia (a condition characterized by progressive or persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking) without behavioral disturbance and anxiety disorder (disorder characterized by feelings of worry or fear that are strong enough to interfere with one's daily activities); - An order for quetiapine (an antipsychotic (a drug that affects the brain activities associated with mental processes and behavior) medication) 25 milligram (mg) at bed time, dated 09/12/24; - No documentation of an appropriate diagnosis for the quetiapine. 2. Review of Resident #11's medical record showed: - admitted on [DATE]; - Diagnosis of dementia; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265550	A. Building B. Wing	11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire Senior Living Advance	315 South Tilley Street Advance, MO 63730

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- An order for quetiapine 200 mg by mouth at bedtime for a diagnosis of unspecified dementia without behaviors, dated 05/15/24; - No documentation of an appropriate diagnosis for the quetiapine; - A pharmacy recommendation, dated 03/28/24, noted the diagnosis of unspecified dementia without behaviors for quetiapine was not appropriate. On 04/10/24, the resident's physician documented the quetiapine couldn't be decreased; - The physician failed to address a correct diagnosis for quetiapine. 3. Review of Resident #15's medical record showed: - An admitted [DATE]; - Diagnoses of parkinsonism (brain conditions that cause slowed movements, stiffness and tremors), neurocognitive disorder (a mental health condition that affects cognitive abilities like learning, memory, problem-solving, and perception), hallucinations (a sensory experience that seems real but is not), repeated falls, major depressive disorder, generalized anxiety disorder, and epilepsy (a chronic brain disorder that causes seizures, which are episodes of abnormal electrical activity in the brain); - An order for haloperidol (an antipsychotic medication), 0.5 mg every four hours as needed, dated 08/26/24 to 02/23/25; - A pharmacy recommendation, dated 08/27/24, noted the haloperidol must be renewed every 14 days by a physician with documentation for the reason to continue. On 09/27/24, the resident's physician documented to continue the resident's haloperidol for hallucinations and paranoia (a state of mind where a person has an irrational and persistent fear of being harmed or deceived by others). During an interview on 11/22/24 at 3:13 P.M., the Director of Nursing (DON) said unspecified dementia without behaviors was not an appropriate diagnosis for an antipsychotic medication. During an interview on 11/22/24 at 3:12 P.M., the Administrator said she expected orders for an antipsychotic medication to have an appropriate diagnosis. During an interview on 12/02/24 at 11:58 A.M., Physician K said that unspecified dementia without behaviors was not an appropriate indication for antipsychotic medication. He/She said that according to his/her records Resident #11 had a diagnosis of unspecified dementia with behavioral disturbance, which would be an appropriate diagnosis, and that when the nurse was entering the order into the electronic medical record, they must have entered the wrong diagnosis. 47678 49999

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265550	A. Building B. Wing	11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire Senior Living Advance	315 South Tilley Street Advance, MO 63730

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 49999 Based on observation, interview and record review, the facility failed to maintain a medication error rate of less than five percent (%). There were 27 opportunities with three errors made, resulting in an error rate of 11.11% for three residents (Residents #1, #8 and #32) out of 12 sampled residents. The facility's census was 34. Review of the facility policy titled, Insulin Pen Injections, undated, showed: - Attach safety needle, turn dose selector to two units and perform airshot (priming), then turn dose selector to required units for injection. 1. Review of Resident #1's medical record showed: - Diagnosis of type 2 diabetes mellitus (a condition in which the body has trouble controlling blood sugar and using it for energy); - An order for insulin lispro pen to be given with meals according to sliding scale, dated 05/22/24. Observation on 11/21/24 at 11:08 A.M., showed: - Certified Medication Technician (CMT) D obtained a blood glucose check for Resident #1; - CMT D administered the insulin lispro dosage as ordered; - CMT D failed to prime the insulin pen with two units prior to dosing and administering the insulin. 2. Review of Resident #8's medical record showed: - Diagnosis of type 2 diabetes mellitus; - An order for Humalog (insulin) Kwik Pen to be given with meals according to sliding scale, dated 06/07/24; - An order for Humalog (insulin) Kwik Pen 3 units to be given with meals, dated 06/28/24. Observation on 11/21/24 at 11:15 A.M., showed: - CMT D obtained a blood glucose check for Resident #8; - CMT D administered the Humalog dosage as ordered; - CMT D failed to prime the insulin pen with two units prior to dosing and administering the insulin. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265550	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire Senior Living Advance	315 South Tilley Street Advance, MO 63730

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Review of Resident #32's medical record showed: - Diagnosis of type 2 diabetes mellitus; - An order for Novolog (insulin) FlexPen 10 units to be given with meals, dated 08/28/24. Observation on 11/21/24 at 11:08 A.M., showed: - CMT D obtained a blood glucose check for Resident #32; - CMT D administered the Novolog dosage as ordered; - CMT D failed to prime the insulin pen with two units prior to dosing and administering the insulin. During an interview on 11/22/24 at 9:36 A.M., CMT D said he/she had never primed insulin pens before. During an interview on 11/22/24 at 9:45 A.M., Licensed Practical Nurse (LPN) E said he/she primed insulin pens prior to administering the prescribed dose. During an interview on 11/22/24 at 3:10 P.M., the Director of Nursing (DON) said she would expect insulin pens to be primed prior to dialing up the dose and administering. During an interview on 11/22/24 at 3:10 P.M., the Administrator said she would expect insulin pens to be primed prior to administration.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265550	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/22/2024
NAME OF PROVIDER OR SUPPLIER Aspire Senior Living Advance		STREET ADDRESS, CITY, STATE, ZIP CODE 315 South Tilley Street Advance, MO 63730	

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 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. 49999 Based on observation, interview, and record review, the facility failed to label and store medications in a safe and effective manner. This had the potential to affect all residents. The facility census was 34. Review of the facility policy titled, Storage of Medications, undated, showed: - No discontinued or outdated medications are to be used and all such medications are destroyed; - Multi-dose vials that have been opened or accessed should be dated and discarded within 28 days of opening unless manufacturer specified a shorter or longer date. Review of the manufacturer's recommendations for Tubersol (a solution used for a tuberculosis (TB - a contagious lung disease) testing showed the medication was to be discarded 30 days after opening. Observation on 11/21/24 at 3:25 P.M., of the medication room refrigerator showed: - Two opened vials of Tubersol with no opened date. Observation on 11/21/24 at 3:25 P.M., of the medication room STAT safe showed: - Two unopened vials of nafcillin (an antibiotic) with an expiration date of 12/2023. Observation on 11/22/24 at 8:58 A.M., of the medication cart showed: - Two labeled and opened Lantus (a type of insulin) pens not dated when opened; - One labeled and opened insulin lispro (a type of insulin) pen not dated when opened; - One labeled and opened insulin aspart (a type of insulin) pen not dated when opened; - Two labeled and opened basaglar (a type of insulin) pens not dated when opened. During an interview on 11/22/24 at 9:36 A.M., Certified Medication Technician (CMT) D said insulin pens were to be dated when opened. He/She checked the dates of medications as they were used and then weekly. During an interview on 11/22/24 at 9:45 A.M., Licensed Practical Nurse (LPN) E said multi-use vials and insulin pens should be dated when they were opened. Medication expiration dates were checked at the end of the month and as they were administered. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265550	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire Senior Living Advance	315 South Tilley Street Advance, MO 63730

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/22/24 at 3:10 P.M., the Director of Nursing (DON) said she would expect multi-dose vials and insulin pens to be dated when they were opened and medications to be check for expiration dates at least monthly. During an interview on 11/22/24 at 3:10 P.M., the Administrator said she would expect medication expiration dates to be checked at least monthly.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265550	A. Building B. Wing	11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire Senior Living Advance	315 South Tilley Street Advance, MO 63730

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 - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49152 Based on observation, interview, and record review, the facility failed to maintain proper infection control practices while providing incontinent care, medication administration/tube feeding (a tube inserted into the abdomen to provide nutrition into the stomach), catheter (a tube inserted into the bladder to drain urine) care, and wound care for three residents (Resident #3, #16, and #237) out of four sampled residents and for one resident (Resident #17) outside the sample. The facility failed to ensure proper Tuberculosis (TB - a communicable disease that affects the lungs, characterized by fever, cough and difficulty breathing) screening of three residents (Residents #6, #12, and #16) out of five sampled residents. The facility's census was 34. Review of the facility's policy titled, Gloves, dated 03/2015, showed: - Wear gloves when it can be reasonably anticipated that hands will be in contact with mucous membranes, non intact skin, any moist body substances (blood, urine, feces, wound drainage, oral secretions, sputum, vomitus, or items/surfaces soiled with these substances) and/or persons with a rash; - Change gloves between contacts with different residents or with different body sites of the same resident. Review of the facility's policy titled, Enhanced Barrier Precautions, undated, showed: - Gown and gloves are to be worn during high-contact activities to all residents with wounds or indwelling medical devices; - High-contact activities includes dressing, bathing, transferring, providing hygiene, changing linens, changing briefs, assisting with toileting, device care, use of device, and wound care. Review of the facility's policy titled, Mantoux (Tuberculosis Screening) Testing- Residents, undated, showed: - Residents will be screened for tuberculosis infections upon their admission to the facility and at intervals appropriate for the regional prevalence of tuberculosis, with screening performed at least annually; - Upon admission to the facility, the resident will be screened for tuberculosis; - A chest x-ray will be obtained within 72 hours if signs of tuberculosis are present, regardless of previous x-ray results or the skin test reaction (if performed); - If the PPD status is unknown or is known to have been negative in the past, the two-step Mantoux test will be administered. 1. Observation on 11/21/24 at 2:25 P.M., of the wound care dressing change for Resident #3 showed: - Signage for EPB precautions; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265550	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/22/2024
NAME OF PROVIDER OR SUPPLIER Aspire Senior Living Advance		STREET ADDRESS, CITY, STATE, ZIP CODE 315 South Tilley Street Advance, MO 63730	

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 - Few	- Certified Nurse Assistant (CNA) J did not put on a gown, entered the room, and assisted with the dressing change. 2. Review of Resident #6's medical record showed: - admitted [DATE]; - No documentation of the two step TB testing. Observation on 11/20/24 at 2:31 P.M., of suprapubic (a flexible tube inserted into the lower abdomen to drain urine from the bladder) catheter care for Resident #6 showed: - Signage for EPB precautions; - CNA G did not put on a gown, entered the room, and performed performed suprapubic catheter care. 3. Review of Resident #12's medical record showed: - admitted [DATE]; - No documentation of the two step TB testing. 4. Review of Resident #16's medical record showed: - admitted [DATE]; - No documentation of the two step TB testing. Observation on 11/20/24 at 8:39 A.M. of Resident #16's incontinent care showed: - CNA A cleaned the resident while CNA C positioned the resident on his/her side; - CNA A removed gloves, did not wash hands, and fastened a clean brief on the resident with his/her bare hands; - CNA C did not change gloves or perform hand hygiene, and touched the sheet and pulled it over the resident; - CNA A, with his/her bare hands, touched the sheet and adjusted it over the resident. During an interview on 11/20/24 at 2:01 P.M., CNA A said gloves should be changed when going from dirty to clean care and hands should be washed after incontinent care had been completed. During an interview on 11/22/24 at 10:30 A.M., CNA C said hand washing should be done before and after incontinent care and gloves should be changed before putting a clean brief on a resident. 5. Observation on 11/19/24 at 2:03 P.M. of incontinence care for Resident #17 showed: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265550	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/22/2024
NAME OF PROVIDER OR SUPPLIER Aspire Senior Living Advance		STREET ADDRESS, CITY, STATE, ZIP CODE 315 South Tilley Street Advance, MO 63730	

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 - Few	- CNA I and CNA J performed hand hygiene and put on gloves; - CNA I and CNA J performed incontinent care; - CNA I and CNA J did not change gloves, did not perform hand hygiene, touched the resident's thighs, lower legs, and feet when rolling the resident to the sides; - CNA I and CNA J did not change gloves, did not perform hand hygiene, and placed a clean brief on the resident; - CNA I and CNA J did not change gloves, did not perform hand hygiene, and put pants on the resident. During an interview on 11/20/24 at 12:50 P.M., CNA I said to change gloves when going from front to back peri care during incontinence care and to wash hands between glove changes and when finished with care. 6. Observation on 11/21/24 at 3:45 P.M., of Resident #237's feeding tube medication administration showed: - Signage for EPB precautions; - Licensed Practical Nurse (LPN) F did not put on a gown, entered the resident's room, and administered medications through the resident's feeding tube. During an interview on 11/20/24 at 2:00 P.M., the Administrator said some residents did not receive their two step TB testing. Observation on 11/22/24 at 12:10 P.M., of Resident #237's tube feeding administration showed: - Signage for EPB precautions; - LPN E did not put on a gown, entered the resident's room, and administered the resident's feeding through the resident's feeding tube. During an interview on 11/22/24 at 9:45 A.M., LPN E said gloves and gowns should be used during care on residents with catheters, wounds, and feeding tubes. During an interview on 11/22/24 at 3:10 P.M., the Administrator and Director of Nursing (DON) said they would expect staff to follow guidelines for enhanced barrier precautions. During an interview on 11/22/24 at 3:22 P.M., the DON said she expected staff should wash hands before and after care, and wash hands and change gloves when when going from dirty to clean care during incontinent care. 49999

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265550	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/22/2024
NAME OF PROVIDER OR SUPPLIER Aspire Senior Living Advance		STREET ADDRESS, CITY, STATE, ZIP CODE 315 South Tilley Street Advance, MO 63730	

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 0947 Level of Harm - Potential for minimal harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 47447 Based on interview and record review, the facility failed to conduct at least twelve hours of nurse aide in-service education per year. This affected one out of two sampled Certified Nurse Assistants (CNA) (CNA B). The facility's census was 34. The facility did not provide a policy regarding in-service training. 1. Record review of CNA B's in-service record showed: - A hire date of 09/01/21; - A total of eight hours of annual in-service training for November 2023 through November 2024; - Less than twelve hours of in-service education for November 2023 through November 2024. During an interview on 11/21/24 at 8:30 A.M., the Director of Nursing (DON) said in-service training was conducted on a monthly basis and all CNA's were expected to attend at least 12 hours of in-service training annually. During an interview on 11/22/24 at 3:20 P.M., the Administrator said she expected CNA's to have at least 12 hours of in-service training annually.