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	03/06/2026

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

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed have an appropriate diagnosis for an antipsychotic (psychiatric medications used to manage psychosis, particularly hallucinations, delusions, and severe agitation) medication for one resident (Resident #16) and failed to limit an as needed (PRN) antipsychotic medication to 14 days for one resident (Resident #27) and out of 12 sampled residents. Facility census was 30. Review of the facility policy titled, Use of Psychotropic Medications, undated, showed:- A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. Psychotropic drugs include, but are not limited to the following categories: antipsychotics ((drugs used to manage some mental health disorders by regulating brain chemicals), antidepressants, anti-anxiety, and hypnotics (medications for sleep);- Psychotropic medications are to be used only when a practitioner determines that the medication(s) is appropriate to treat a resident's specific, diagnosed, and documented condition and the medication(s) is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication;- The indications for initiating, maintaining, or discontinuing medications(s), as well as the use of non?pharmacological approaches, will be determined by evaluating the resident's physical, behavioral, mental, and psychosocial signs and symptoms in order to identify and rule out any underlying medical conditions, including the assessment of relative benefits and risks, and the preferences and goals for treatment;- The resident's medical record shall include documentation of this evaluation and the rationale for chosen treatment options. This includes any indicated documentation of rationale for prescribing multiple psychotropic medications or switching from one type of psychotropic medication, specifically an antipsychotic medication, to another category of psychotropic medication;- The attending physician will assume leadership in medication management by developing, monitoring, and modifying the medication regimen in collaboration with residents, their families and/or representatives, other professionals, and the interdisciplinary team;- Psychotropic medications used on a PRN basis must have a diagnosed specific condition and indication for the PRN use documented in the resident's medical record and is subject to the limitations as noted: PRN orders for psychotropic medications, excluding antipsychotics, shall be limited to no more than 14 days, unless the attending physician or prescribing practitioner believes it is appropriate to extend the order beyond the 14 days. The medical record should include documentation from the physician or prescriber for the rationale for the extended time period and indicate a specific duration. PRN orders for antipsychotic medications only, shall be limited to 14 days with no exceptions. If the attending physician or prescribing practitioner believes it is appropriate to write a new order for the PRN antipsychotic, they must first evaluate the resident to determine if the new order for the PRN antipsychotic is appropriate. 1. Review of Resident #16's medical record showed:- admitted on [DATE];- Diagnoses of drug induced dyskinesia (involuntary uncontrollable movements), polyneuropathy (disorder affecting nerves in the body), Parkinson's (progressive neurological disorder affecting movement) disease with dyskinesia, and depression (a serious medical illness that negatively affects how you feel, the way you think, and how you act);- An order for quetiapine (an (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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	antipsychotic medication) 25 milligrams (mg) by mouth one time a day for depression, dated 02/07/26.- A Monthly Medication Review (MMR), dated 02/12/26, the pharmacist requested the quetiapine dosage be decreased but did not address the inappropriate diagnosis of depression;- The facility failed to have an appropriate diagnosis for the quetiapine. 2. Review of Resident #27's medical record showed:- admitted on [DATE];- Diagnoses of dementia (a disorder marked by memory loss, personality changes, and impaired reasoning that interferes with daily functioning) with mood disturbance, major depressive disorder (MDD - a long-term loss of pleasure or interest in life), anxiety (persistent worry and fear about everyday situations), neurocognitive disorder with Lewy bodies (a progressive, incurable disease characterized by abnormal protein clumps that destroy brain cells, leading to cognitive decline, visual hallucinations, parkinsonian movement issues, and fluctuating alertness), epilepsy (a disease that causes recurrent 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)), pain, agitation and restlessness, fibromyalgia (widespread musculoskeletal pain and fatigue throughout the body), hallucinations, and Parkinson's disease;- An order for haloperidol (an antipsychotic medication) 0.5 mg by mouth every 6 hours PRN for hallucinations, dated 09/05/25 with no stop date;- Pharmacy Note, dated 01/16/26, requested attending physician/prescriber to address the order of haloperidol 0.5 mg every six hours PRN with no stop date. On 01/16/26, the physician responded to continue the PRN haloperidol 0.5 mg every 6 hours PRN for psychosis (disconnection from reality), but did not address a stop date. During an interview on 02/27/26 at 1:21 P.M., the Director of Nursing (DON) and the Administrator said they would expect medications to have an appropriate diagnosis. The Administrator said she would expect PRN psychotropic medications to have a 14 day stop date or another designated stop date if appropriate. Pharmacy sent the recommendations, and the facility had the physician look at it and address the recommendations. Pharmacy sent a monthly report and the DON forwarded the recommendations to the appropriate providers and followed up on those recommendations. During an interview on 03/05/26 at 1:10 P.M., the Medical Director (MD) said depression was not an appropriate diagnosis for quetiapine. PRN antipsychotic medications should have a stop date of 14 days. He/She attempted to address medications for Resident #27, but hospice disagreed. He/She does not like to use antipsychotic medications and would try to get Resident #16 off as soon as possible.

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow physician orders when administering a medication as ordered for one resident (Resident#18) out of 12 sampled residents and during wound care for one resident (Resident #26) out of three sampled residents. The facility census was 30.The facility did not provide a policy for following physician orders. 1. Review of Resident #18's medical record showed:- admitted on [DATE];- Diagnosis of type 2 diabetes mellitus (a chronic condition causing high blood sugar);- An order for Lantus (a long-acting insulin) 8 units subcutaneously (an injection under the skin) at bedtime related to type 2 diabetes mellitus, dated 10/27/25. Review of the resident's Medication Administration Record (MAR), dated October 2025 - February 2026, showed:- Lantus (a long-acting insulin) 8 units subcutaneously at bedtime;- For October 2025, the resident didn't receive the Lantus dose 10/29/25 for a blood sugar (bs)=166, with one missed out of 31 opportunities to receive the Lantus dose;- For November 2025, the resident didn't receive the Lantus dose on 11/04/25 for bs=162, 11/07/25 for bs=162, 11/10/25 for bs=176, 11/18/25 for bs=129, 11/20/25 for bs=147, and 11/27/25 for bs=162, with six missed out of 30 opportunities to receive the Lantus dose;- For December 2025, the resident didn't receive the Lantus dose on 12/02/25 for bs=142, 12/03/25 for bs=167, 12/09/25 for bs=168, 12/10/25 for bs=126, 12/16/25 for bs=143, 12/17/25 for bs=166, 12/22/25 for bs=162, 12/24/25 for bs=144, 12/25/25 for bs=176, and 12/31/25 for bs=146, with 10 missed out of 31 opportunities to receive the Lantus dose;- For January 2026, the resident didn't receive the Lantus dose on 01/01/26 for bs=130, 01/02/26 for bs=174, 01/04/26 for bs=115, 01/05/26 for bs=172, 01/07/26 for bs=157, 01/10/26 for bs=169, 01/14/26 for bs=167, 01/22/26 for bs=168, 01/23/26 for bs=132, 01/26/26 for bs=128, 01/27/26 for bs=122, 01/28/26 for bs=158, 01/29/26 for bs=118, and 01/30/26 for bs=155, with 14 missed out of 31 opportunities to receive the Lantus dose;- For February 2026, the resident didn't receive the Lantus dose on 02/02/26 for bs=122, 02/04/26 for bs=166, 02/10/26 for bs=152, 02/11/26 for bs=140, 02/12/26 for=bs 146, 02/13/26 for bs=141, 02/16/26 for bs=168, 02/18/26 for bs=133, 02/25/26 for bs=144, with nine missed out of 25 opportunities to receive the Lantus dose. During an interview on 02/26/25 at 3:26 P.M., Registered Nurse (RN) A said insulin should be given as ordered. If the resident's blood sugar was under 70, he/she would give the resident a snack and then give the Lantus. He/She did not know why the resident's Lantus was held other than maybe nursing judgment. During an interview on 03/05/26 at 1:10 P.M., the Medical Director said physician orders should be followed as ordered. If there was a concern about an order, the facility should notify the physician for clarification. He/She would expect ordered insulin to be administered unless the blood sugar was low. During an interview at 2:55 P.M., Licensed Practical Nurse (LPN) D said he/she did not hold Resident #18's Lantus. He/She must have charted incorrectly because he/she administered Resident #18's Lantus doses on the dates shown as not administered from October 2025 - February 2026. If medication was given and it was documented as given in the electronic medical record, it would show as administered. He/She would notify the resident's physician if his/her blood sugar was below 90 as that would be low for Resident #18. He/She did not notify the physician regarding Resident #18's blood sugars. 2. Review of Resident #26's medical record showed:- admitted on [DATE];- Diagnoses of venous insufficiency (inefficient blood return to the heart), non-pressure chronic ulcer of other part of left lower leg, non-pressure chronic ulcer of other part of right lower leg with bone involvement, and peripheral vascular disease (impaired blood flow);- An order for the left heel to cleanse with Vashe (a cleaning solution usually applied to wounds), apply skin prep (a protective barrier) to the peri wound (the skin immediately surrounding a wound), apply mupirocin (an antibiotic) ointment followed by calcium alginate silver (a type of wound dressing) dressing, cover with ABD pad (wound dressing material), and wrap with gauze daily and as needed (PRN) for soiling and/or unscheduled removal every day shift for wound treatment until healed, dated 02/17/26;- An order for the left (continued on next page)

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	265550	A. Building B. Wing	03/06/2026

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medial (middle) ankle to cleanse with Vashe, apply skin prep to the peri wound, apply mupirocin ointment followed by calcium alginate silver dressing, cover with ABD pad, and wrap with gauze daily and PRN for soiling and/or unscheduled removal every day shift for wound treatment, dated 02/17/26;- An order for the left posterior (back) leg to cleanse with Vashe, apply skin prep to the peri wound then apply calcium alginate silver dressing, cover with ABD pad, and wrap with gauze daily and PRN for soiling and/or unscheduled removal every day shift, dated 02/03/26;- An order for mupirocin ointment apply to the wounds to the bilateral (both) lower extremities topically every day shift for wound treatment, dated 02/17/26. Observation on 02/25/26 at 2:50 P.M., of the resident's wound care showed:- The Director of Nursing (DON) provided the treatment to the resident's left heel but did not apply the skin prep to the peri wound and the mupirocin ointment to the heel wound as ordered;- The DON provided the treatment to the resident's left posterior leg wound but did not apply the skin prep to the peri wound as ordered. During an interview on 02/25/26 at 3:00 P.M., the DON said she forgot to apply the skin prep and the mupirocin ointment to the resident's left leg/heel as ordered. During an interview on 02/27/26 at 1:21 P.M., the Administrator and the DON said they would expect physician orders to be followed as ordered. The Administrator said insulin should be held if the physician had written specifically the insulin be held dependent on the resident's blood sugar levels.

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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** Based on interview and record review, the facility failed to ensure a resident 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 services to promote the resident's highest level of functioning and psychosocial needs for two residents (Residents #5 and #27) out of three sampled residents with dementia. The facility census was 30.The facility did not provide a policy regarding dementia care. Review of the facility's policy titled, Comprehensive Care Plans, dated 2025, showed: - It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and all services that are identified in the resident's comprehensive assessment and meet professional standards of quality; - The comprehensive care plan will describe, at a minimum, the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. 1. Review of Resident #5's medical record showed: - An admission date of 03/04/25; - Diagnoses of unspecified dementia and Alzheimer's disease (a progressive disease that destroys memory and other important mental functions). Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by the facility staff), dated 01/05/26, showed: - Diagnosis of dementia; - Moderate cognitive impairment. Review of the resident's Care Plan, revised 12/30/25, 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. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of Resident #27's medical record showed: - admitted on [DATE]; - Diagnoses of dementia, hallucinations, restlessness and agitation. Review of the resident's quarterly MDS, dated [DATE], showed: - Diagnosis of dementia; - Cognitive impairment; - Inattention, disorganized thinking, and altered level of consciousness fluctuated. Review of the resident's Care Plan, reviewed 02/26/25, showed: - Failed to address dementia; - Failed to address specific problems, interventions, or goals for dementia care; - Failed to address specific problems, interventions, or goals for activities for a resident diagnosed with dementia. During an interview on 02/27/26 at 9:30 A.M., the MDS Coordinator said the care plan should address dementia with personalized interventions. During an interview on 02/27/26 at 1:30 P.M., the Administrator said she would expect the care plan to reflect a diagnosis of dementia. During an interview on 02/26/26 at 2:30 P.M., the Activity Director said he/she just started at the beginning of February, and the facility did not have any specialized activities for dementia residents.

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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 medications and biologicals were labeled in accordance with currently accepted practices for one resident (Resident #27) for one out of one sampled medication cart and one out of one sampled medication room. This practice had the potential to affect all residents. The facility's census was 30. Review of the facility policy titled, Medication Labeling and Storage, undated, showed:- All medications and biologicals will be labeled in accordance with applicable federal and state requirements and current accepted pharmaceutical principles and practices;- Labels for multi-use vials must include the date the vial was initially opened;- All opened or accessed vials should be discarded within 28 days unless the manufacturer specifies a different date. Review of the manufacturer's guidelines for tuberculin purified protein derivative (a medication used to diagnose tuberculosis (TB - a contagious, often severe lung infection) solution, undated, showed:- Discard 30 days after opening. Review of the package insert for methadone (an opioid medication pain medication) concentrate, dated April 2015, showed:- Discard opened bottle after 90 days. 1. Review of Resident #27's medical record showed:- An order for methadone concentrate 10 milligram (mg) per milliliter (ml) 0.5 ml by mouth every 1 hour as needed for pain, dated 11/18/24, and a start date of 12/03/24;- No adverse reactions identified related to the methadone use. Observation of the 200 Hall medication cart on 02/25/26 at 1:55 P.M., showed:- An opened bottle of methadone concentrate 10mg/ml with 17 ml remaining, not dated, for Resident #27. Review of the 200 Hall Controlled Medication Count Sheet for Resident #27's methadone showed:- Administered first dose from bottle on 04/16/25;- Administered a dose on 10/04/25, 81 days after the expiration date of 07/15/25;- Administered a dose on 10/28/25, 105 days after the expiration date of 07/15/25;- Administered a dose on 11/11/25, 119 days after the expiration date of 07/15/25;- Administered a dose on 12/09/25, 147 days after the expiration date of 07/15/25;- Administered a dose on 12/30/25, 168 days after the expiration date of 07/15/25;- Administered a dose on 01/01/26, 170 days after the expiration date of 07/15/25;- Administered a dose on 01/02/26, 171 days after the expiration date of 07/15/25;- Administered a dose on 01/03/26, 172 days after the expiration date of 07/15/25;- Administered a dose on 01/08/26, 177 days after the expiration date of 07/15/25;- Administered two doses on 01/21/26, 190 days after the expiration date of 07/15/25;- Administered a dose on 01/26/26, 195 days after the expiration date of 07/15/25;- Administered a dose on 02/10/26, 210 days after the expiration date of 07/15/25;- The methadone was administered to the resident a total of 13 times beyond the 90-day expiration date. During an interview on 02/25/26 at 3:21 P.M., Registered Pharmacist F said methadone concentrate remained stable for up to 90 days after opening at room temperature. 2. Observation of the medication storage room refrigerator on 02/25/26 at 2:10 P.M., showed:- An opened tuberculin purified protein derivative one ml multidose vial, not dated. During an interview on 02/25/26 at 2:11 P.M., Registered Nurse (RN) E said the tuberculin solution should be dated when opened and discarded when expired per the directions on the box. During an interview on 02/25/26 at 3:10 P.M., the Minimum Data Set (MDS - a federally mandated assessment completed by the facility) Coordinator said the tuberculin solution should be dated when opened and discarded per the manufacturer's guidelines and medications should be discarded per the facility policy. During an interview on 02/25/26 at 3:15 P.M., the Administrator said multi-dose vials should be dated when opened and discarded when expired. During an interview on 02/27/26 at 1:21 P.M., the Administrator and the Director of Nursing said expired medications should not be administered to the residents.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store and distribute food under sanitary conditions, increasing the risk of cross-contamination and food-borne illness. This had the potential to affect all residents. The facility census was 30. Review of the facility's policy titled, Cleaning, dated 01/30/24, showed: - All equipment, food contact surfaces, and utensils shall be cleaned each time there is a use with a different type of raw animal product, each time there is a change from working with raw foods to ready-to-eat foods, whenever contamination may have occurred;- All food surfaces will be cleaned at the end of each food preparation session;- Refrigerator units must be cleaned. Review of the facility's policy titled, Food Safety Requirements, undated, showed: - Facility staff shall inspect all food, food products, and beverages for safe transport and quality upon delivery/receipt and ensure timely and proper storage;- Follow contract/vendor procedures when food arrives damaged, or concerns are noted and remove these foods from use;- Practices to maintain safe refrigerated storage include labeling, dating, and monitoring refrigerated food, including leftovers, so it is used by its use-by date or frozen/discarded and keeping foods covered or in tight containers. Review of the facility's policy titled, Storage of Food in Refrigeration, dated 01/30/24, showed: - All containers must be labeled with the contents and date food item was placed in storage;- Previously cooked foods can be held in refrigeration of 41 degrees Fahrenheit or lower for up to three days and then must be discarded. Review of the February 2026 Dietary [NAME] Cleaning List on 02/24/26 at 9:45 A.M., showed: - No documentation the bottom of the fridge was cleaned daily from 02/19/26 - 02/28/26, with 10 out of 28 missed opportunities;- No documentation for the completion of the weekly duties for the month of February with four out of four missed opportunities;- Microwave and air fryer not addressed on the cleaning list. Observations of the kitchen on 02/24/26 at 9:45 A.M., and 02/27/26 at 11:30 A.M., showed:- Food particles in the bottom and brown grime on the top of the inside of the microwave;- The air fryer basket coated with black build up and food crumbs;- The air fryer handle with grime and food particles;- One 12-quart (qt.) container of shell noodles without a label or date;- One 12-qt. container of brown sugar without a label or date;- One four-liter (L) container labeled baking powder without a date;- One 22-qt. container of white sugar, incorrectly labeled brown sugar, dated 01/25/26;- One 6 pound (lb.) 15 ounce (oz.) can of black-eyed peas dented;- One 16 oz. bag of shelled pecans opened, exposed to air, and without a date opened. Observation of the reach-in cooler on 02/24/26 at 9:45 A.M., and 02/27/26 at 11:30 A.M., showed: - Food particles and a two inch (in.) by four in. dried brown substance on the floor of the cooler;- An uncovered head of cabbage shriveled and brown in spots;- One gallon (gal.) size bottle of ranch dressing, one third full, without a date opened;- One gal. size bottle of heavy-duty mayonnaise one half full, without a date opened;- One gal. size bottle one third full with the manufacturer's label of sweet pickle relish, containing a white substance with green particles. During an interview on 02/27/26 at 11:37 A.M., Dietary [NAME] G said he/she had not cleaned the air fryer or microwave and was not sure when they need to be cleaned. All items should be labeled and dated with the date opened and said there was nothing wrong with dented cans. During an interview on 02/27/26 at 11:45 A.M., the Dietary Manager said all items removed from their original packaging should be labeled and dated, items should be dated when opened, dented cans should be removed from other items, and should not be used, and all food items should be covered. He was aware more cleaning needed to be done but had been unable to do it due to the lack of staffing, and the cleaning schedule should be signed off when each task was completed. During an interview on 02/27/26 at 1:21 P.M., the Administrator said dented food cans should be returned to the food distributor, food should be labeled and dated with the date opened, and all equipment should be in good working order and cleaned per the cleaning schedule.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to follow infection prevention measures when staff did not properly disinfect the glucometer (a portable device used to measure blood sugar levels) for four residents (Residents #1, #4, #18, and #28) out of four sampled residents. The facility census was 30.Review of the facility policy titled, Glucometer Disinfection, undated, showed: - The facility will ensure blood glucometers will be cleaned and disinfected after each use and according to manufacturer's instructions for multi-resident use. Review of the manufacturer's guidelines titled, Quintet AC Blood Glucose Meter Owner's Manual, undated, showed: - The following cleaning and disinfecting steps to be performed after each use: - Thoroughly wipe the entire surface of the meter with disinfecting wipes to clean any possible dirt, blood, and other body fluids; - Take another disinfecting wipe and wipe the meter thoroughly; - Allow the surface to remain wet for two minutes; - Allow to air dry. Review of the manufacturer's guidelines titled, Super Sani-Cloth General Guidelines for Use, undated, showed: - Use a wipe to remove visible soil prior to disinfecting; - Unfold a clean wipe and thoroughly wet surface; - Allow treated surface to remain wet for two minutes; - Let air dry; - Dispose of used towelette in trash. 1. Observation on 02/24/26 at 3:07 P.M., of Resident #18's blood glucose testing showed: - Certified Medication Technician (CMT) C performed the resident's blood glucose testing with the first glucometer; - CMT C wiped the first glucometer with a Super Sani-Cloth and did not allow the glucometer surface to remain wet for two minutes. (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	03/06/2026

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	Observation on 02/24/26 at 3:13 P.M., showed: - CMT C removed a second glucometer from the medication room; - CMT C wiped the second glucometer with a Super Sani-Cloth and did not allow the glucometer surface to remain wet for two minutes. Observation on 02/24/26 at 3:13 P.M., of Resident #28's blood glucose testing showed: - CMT C performed the resident's blood glucose testing with the first glucometer; - CMT C wiped the first glucometer with Super Sani-Cloth and did not allow the glucometer surface to remain wet for two minutes. Observation on 02/24/26 at 3:24 P.M., of Resident #4's blood glucose testing showed: - CMT C performed the resident's blood glucose testing with the second glucometer; - CMT C wiped the second glucometer with a Super Sani-Cloth and did not allow the glucometer surface to remain wet for two minutes. Observation on 02/24/26 at 3:34 P.M., of Resident #1's blood glucose testing showed: - CMT C performed the resident's blood glucose testing with the first glucometer; - CMT C wiped the first glucometer with a Super Sani-Cloth and did not allow the glucometer surface to remain wet for two minutes. During an interview on 02/24/26 at 3:45 P.M., CMT C said he/she was taught to wipe the glucometer down with a Super Sani-Cloth and then use another glucometer while the other one air dried. He/She was not aware of a wet contact time. During an interview on 02/24/26 at 4:00 P.M., the Director of Nursing (DON) said she expected her staff to wrap the glucometer with a Super Sani-Cloth for the wet contact time on the label of the wipes to sanitize the glucometer between residents. During an interview on 02/27/26 at 1:21 P.M., the Administrator said she would expect glucometers to be disinfected per the facility policy.