

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265565	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/27/2025
NAME OF PROVIDER OR SUPPLIER Aspire Senior Living Pleasant Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 1300 Broadway Pleasant Hill, MO 64080	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure staff performed urinary catheter placement according to acceptable standards of practice for one sampled resident (Resident #1) out of 16 sampled residents resulting in pain and the presence of blood on the resident's bed after Licensed Practical Nurse (LPN) A attempted to insert the urinary catheter. The facility census was 83 residents.</p> <p>Review of the Facility's Nursing Procedures Manual for Urinary Catheterization revised 3/30/17 showed:</p> <ul style="list-style-type: none"> -Catheters were to have been inserted by licensed nurses under the orders of the attending physician. -The standard of practice did not support routine changing of urinary catheters at any fixed interval. -The standard for urinary catheters was to change them as needed only. -The procedure for placing urinary catheters showed that after sterilizing the resident's perineal area (surface area between the thighs extending from the pubic bone to the tail bone), the tip of the urinary catheter tubing was to have been well lubricated up the tube approximately two to two and one-half inches. -The urinary catheter was to have then been gently inserted into the meatus (external opening of the urinary tract) approximately two to three inches or until urine flowed from the bladder. -If resistance was continually met, the nurse was not to have forced entry and report the issue to the nursing supervisor. <p>1. Review of Resident #1's Facility Face Sheet showed the resident was admitted on [DATE] with the following diagnoses:</p> <ul style="list-style-type: none"> -Neurocognitive disorder with Lewy Bodies (a type of dementia characterized by changes in sleep, behavior, cognition, movement, and regulation of automatic bodily functions). <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Dementia (a progressive organic mental disorder characterized by chronic personality disintegration, confusion, disorientation, stupor, deterioration of intellectual capacity and function, and impairment of control of memory, judgment, and impulses).</p> <p>-Vancomycin-Resistant Enterococci (VRE-antibiotic resistant bowel infection) of the urine.</p> <p>Review of the resident's quarterly Minimum Data Set (MDS-a federally mandated assessment tool completed by facility staff and used for care planning) dated 3/12/25 showed he/she was moderately cognitively intact.</p> <p>Review of the resident's Physician's Order Sheet (POS) dated 5/13/25 showed the resident's Urinary Analysis (UA) came back positive for VRE, therefore the resident required a urinary catheter be placed to contain the urine for isolation purposes to prevent transmission.</p> <p>Review of the resident's Nurse's Notes dated 5/13/25 at 10:33 P.M., showed:</p> <p>-The resident told LPN C that LPN A was unable to place the urinary catheter and the resident was still in a lot of pain from it.</p> <p>-LPN C noted blood in the resident's brief but no visible external injuries.</p> <p>-An ambulance was called to have the resident taken to the hospital for evaluation and treatment.</p> <p>-LPN C spoke to the hospital emergency room (ER) nurse who stated they would do a urine test as well as a Computed Tomography (CT- scan, is a medical imaging technique that uses X-rays to create detailed cross-sectional images of the body) of the resident's abdomen and pelvis to check for any internal injuries.</p> <p>Review of LPN C's written statement dated 5/13/25 showed:</p> <p>-Around 5:30 P.M., LPN C noticed the resident had straight urinary catheter materials in his/her room but no catheter bag so he/she asked the resident if anyone had inserted his/her catheter.</p> <p>-The resident said no, the nurse had tried but couldn't get it in.</p> <p>-The resident said the nurse got a little urine in the tube and then left.</p> <p>-LPN C notified the former DON and Administrator A.</p> <p>During an interview on 6/3/25 at 3:30 P.M., LPN C said:</p> <p>-At around 5:30 P.M., he/she noted LPN A coming out of the resident's room.</p> <p>-He/She knew the resident was to have had a urinary catheter placed so he/she asked the resident if that had been done or not.</p> <p>-The resident then told him/her that LPN A tried to get the urinary catheter placed but was unsuccessful and left without placing the catheter.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-The resident was sent to the hospital for evaluation of any potential trauma.</p> <p>-The resident returned from the hospital with no evidence of trauma.</p> <p>During an interview on 5/27/25 at 1:15 P.M., the resident said:</p> <p>-He/She did not recall anything about his/her urinary catheter placement.</p> <p>-He/She did not remember anything about the nurse or the events of 5/13/25.</p> <p>-He/She stated, My memory isn't so good anymore.</p> <p>During an interview on 5/27/25 at 4:15 P.M., the DON and Administrator B said:</p> <p>-They would have expected that given LPN A appeared to be impaired, or at the least, struggling with his/her shift, that he/she would not have attempted to place a urinary catheter in the resident.</p> <p>-They never wanted any harm to come to a resident at the hand of a staff member.</p> <p>-They would have expected the employee to have submitted a urine drug screen on site and that as soon as there was sufficient indications from other employees that LPN A was behaving in a manner which could have been reasonable suspicion of working under the influence, LPN A would have been removed from resident care and tested.</p> <p>-They would have expected if there were issues in inserting the urinary catheter the nurse would have asked for assistance and/or notified the DON.</p> <p>MO00254215</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to keep two residents (Resident #4 and #16), safe from possible narcotic misappropriation when three milliliters (mls) was missing from Resident #4 and four mls from Resident #16's personal supply out of 16 sampled residents. The facility census was 83 residents.</p> <p>Review of the facility policy for Inventory Control of Controlled Substances revised 1/1/2013 showed:</p> <ul style="list-style-type: none"> -The purpose of the policy was to set forth the procedures for inventory control of controlled substances. -The facility was to have maintained separate individual controlled substance records on all controlled substances with a potential for abuse or diversion in the form of declining inventory using the Controlled Substances Declining Inventory Record. -The Inventory Record was to show the resident's name, prescription number, medication name, strength, dosage form, dosage, total quantity received by the facility, the date and time of administration and the signature of the person administering the medication. -The facility staff was not to enter more than one prescription for a controlled substance medication on each page of a declining inventory record. -The facility staff was to ensure that the incoming and outgoing nurses count all controlled substances and other medication with a risk of abuse or diversion at the change of each shift or at least once daily and document the results on the Controlled Substance Count Verification/Shift Count Sheet. -The facility nurses were to reconcile the total number of controlled medications on hand, add newly received medications to the inventory and remove medications that were not completed or discontinued from the inventory. -The staff nurses were to reconcile the number of doses remaining in the package to the number of remaining doses recorded on the Controlled Substance Verification/Shift Count Sheet. -The facility nurses should routinely reconcile the number of doses remaining in the package to the number of remaining doses recorded on the Controlled Substance Verification/Shift Count Sheet, to the medication administration record. -The facility was to ensure that staff immediately reported suspected theft or loss of controlled substances to their supervisor/manager for appropriate documentation, investigation, and timely follow-up. -Upon receipt of such a report, the facility was to have ensured that the appropriate facility personnel confirm the discrepancy and follow facility policy and applicable law regarding documentation of the incident. <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-The facility should have also investigated to determine whether a dose was in fact administered and, if so, the reason the administration was not charged as well as whether a dose was refused by a resident.</p> <p>-A facility representative should have regularly checked the inventory records to reconcile inventory.</p> <p>-They should have reconciled current and discontinued inventory of controlled substances to the log used in facility's controlled medication inventory system; current inventory to the controlled medication declining inventory record and to the resident's Medication Administration Record (MAR); and, unused controlled substances held in storage awaiting destruction to the declining inventory record.</p> <p>1. Review of Resident #4's admission Record showed he/she was admitted with the following diagnoses:</p> <p>-Congestive Heart Failure (CHF- a disorder that impairs the ability of the heart to fill with or pump a sufficient amount of blood throughout the body).</p> <p>-Dilated Cardiomyopathy (a condition where the heart muscle weakens and the heart's chambers, especially the ventricles, enlarge causing symptoms including shortness of breath).</p> <p>-Chronic Obstructive Pulmonary Disease (COPD - a disease process that decreases the ability of the lungs to perform ventilation).</p> <p>Review of the resident's May 2025 Physician Order Sheet (POS) showed a physician order for Morphine Sulfate 100/milligrams (mgs) (20 mgs/ml) oral concentrate, 0.25 mls (5 mgs) by mouth or under the tongue every three hours as needed for pain or shortness of air.</p> <p>Review of the resident's quarterly Minimum Data Set (MDS-a federally mandated assessment tool completed by facility staff and used for care planning) date 5/6/25 showed he/she:</p> <p>-Was cognitively intact.</p> <p>-Had no stated pain during the look-back period.</p> <p>-Had shortness of air with exertion.</p> <p>During an interview on 5/23/25 at 3:05 P.M., Resident #4 said:</p> <p>-He/She was doing okay.</p> <p>-He/She was not aware any Morphine was taken from him/her.</p> <p>-He/She never missed a dose when asked for Morphine.</p> <p>-He/She mainly took the Morphine for shortness of breath.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Review of Resident #16's Facility Face Sheet showed he/she was admitted on [DATE] with the following diagnoses:</p> <ul style="list-style-type: none"> -Pneumonia (inflammation of one or both lungs with consolidation). -Chronic respiratory failure with hypoxia (a long-term condition where the lungs are unable to adequately exchange oxygen and carbon dioxide, resulting in persistent low blood oxygen levels). <p>Review of the resident's significant change MDS dated [DATE] showed he/she was severely impaired.</p> <p>Review of the resident's POS dated 5/20/25 showed he/she no longer had a current order for Morphine.</p> <p>3. Review of the Facility Verification of Investigation dated 5/13/25 showed:</p> <ul style="list-style-type: none"> -LPN A was reported to the former Director of Nursing (DON) as suspected to have been working impaired during his/her shift on 5/13/25. -Licensed Practical Nurse (LPN) A was informed he/she needed to count the narcotics he/she was responsible for with another nurse. -Once he/she was told to count the narcotics, he/she handed his/her keys to another nurse and walked away leaving the facility to smoke a cigarette with the Administrator's knowledge. -The narcotics were immediately recounted by the former DON and two additional nurses and there was a noted discrepancy with the liquid Morphine for two residents, Resident #4 and Resident #16. -The unaccounted for Morphine was a combined total of 7 mls. -Resident #16 no longer had an active order for Morphine, and a new prescription was requested from the physician for Resident #4 to allow the facility to replace the resident's Morphine at the facility's cost. <p>Review of LPN B's written statement dated 5/13/25 showed: on 5/13/25 at around 5:00 P.M., a full narcotics count was completed which showed two resident's Morphine liquid medication counts off.</p> <p>Review of LPN C's written statement dated 5/13/25 showed:</p> <ul style="list-style-type: none"> -He/She and LPN B counted the narcotics and noted that two separate Morphine count numbers were off. -LPN C notified the former DON, Administrator A and the regional nurse. <p>Review of the City Police Report for LPN A dated 5/13/25 at 8:11 P.M., showed:</p> <ul style="list-style-type: none"> -The offense was listed as Abuse of healthcare recipient-physical, sexual, or emotional harm or injury. <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-The Incident Code was listed as stealing.</p> <p>-Administrator A was then advised there were two liquid Morphine counts off during shift narcotic count.</p> <p>-Administrator A also told city police that the Morphine bottles that had been tampered with were secured in an office where LPN A could not access them.</p> <p>-He/she also advised city police there was a total of 6.75 mls missing from the narcotics drawer in the medication cart from the start of the shift to the change of shift.</p> <p>-There were 3.75 mls missing from one Morphine bottle and 3.0 mls missing from a bottle that had been ordered for Resident #16 and had never been used.</p> <p>-The seal on the new bottle had been clearly tampered with.</p> <p>MO00254220</p>