

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265566	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/29/2025
NAME OF PROVIDER OR SUPPLIER  Aspire Senior Living Warsaw		STREET ADDRESS, CITY, STATE, ZIP CODE  1609 Sunchase Drive Warsaw, MO 65355	

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 0600  Level of Harm - Actual harm  Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.  (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0600  Level of Harm - Actual harm  Residents Affected - Few	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, facility staff failed to keep two residents (Resident #1 and #2) free from physical abuse when Certified Nurse Aide (CNA) A forcefully transferred the residents from their beds to their wheelchairs. The facility census was 83. The administrator was notified on 10/29/25 of past Non-Compliance, which occurred on 10/22/25 when staff reported the allegation. Staff immediately suspended CNA A pending the results of the investigation; assessed the resident for physical and psychological harm; investigated; in-serviced staff on abuse, neglect, proper transfer techniques, and resident rights; and terminated the employee on 10/28/25. 1. Review of the facility's Abuse &amp; Neglect Policy and Procedure, revised 04/16/24, showed the purpose of the policy is to ensure residents are free from abuse, neglect, misappropriation of resident's property, and exploitation. 2. Review of the facility's investigation, dated 10/22/25, showed the administrator documented CNA B and C notified Licensed Practical Nurse (LPN) D they witnessed CNA A transfer the residents in a forceful manner, and without the use of a gait belt. Review of the facility's investigation, dated 10/22/25, showed LPN D's signed statement dated 10/22/25. LPN D documented CNA B and C notified him/her CNA A was rough while getting Resident #1 and Resident #2 up for breakfast. He/She documented CNA B and C were, visibly upset, and CNA C was tearful. He/She documented they immediately notified the administrator. Review of CNA B's signed statement, dated 10/22/25, showed he/she documented he/she witnessed abuse by CNA A to Resident # 2 on 10/22/25 between 6:15 A.M. and 6:30 A.M. He/She tried to give report to CNA A on 'A' hall and witnessed him/her out of anger swiftly put Resident #2 into his/her chair, like as in seconds the resident was from bed to chair and then CNA A went to Resident #1 and attempted to transfer him/her in the same way when Resident #1 fought back and was swinging on CNA A and trying to bite him/her when at that point CNA A said to Resident #1, If you hit me again, I'll walk out.' Review of CNA C's signed statement, dated 10/22/25, showed he/she documented CNA A was, extremely aggravated and behaving aggressively, speaking very angrily about how his/her residents were not up. He/She documented CNA A, CNA B, and he/she, entered Resident #1's and Resident #2's room, and without notifying or at all speaking to Resident #2, CNA A immediately grabbed him/her under his/her shoulders and violently yanked him/her out of bed, twisted Resident #2 around and dropped him/her into a wheelchair. He/She then lowered the back of the wheelchair and grabbed Resident #2 underneath his/her shoulders again, and very roughly and suddenly yanked resident #2 again to pull him/her farther into the wheelchair. During all of this, Resident #2 was visibly and verbally confused and upset, and most of all frightened. CNA A immediately went to go and get up Resident #1 and pull him/her out of bed and into the wheelchair. Review of CNA A's signed statement, dated 10/22/25, showed CNA A documented he/she came on duty on 10/22/25 at 6:11 A.M. He/She documented he/she, got to grab Resident #2, got him/her up, and go over to Resident #1 who had taken his/her brief off. CNA A documented he/she refastened the brief. He/She documented Resident # 2 is very contracted. It's a struggle a lot of times to get him/her to roll and move around. I finally got his/her clothes on and brief go to sit him/her up in sitting position resident bit me and when I got him/her in chair he/she punched me a few times. I knew I should have left him/her in bed, but he/she is a resident who needs assist with feedings and is not allowed to eat in bed. Review of the facility's investigation, dated 10/28/25, showed the administrator documented he/she terminated CNA A on 10/28/25 for roughness with resident transfer, violating safety rules by transferring Resident #1 and Resident #2 without a second person, and resident rights. The administrator documented Resident #1 stated CNA A hurt his/her arm. 3. Review of Resident #1's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 09/22/25, showed staff assessed the resident with cognitive impairment, totally dependent for toileting and bathing, substantial assistance required for dressing, hygiene, and transfers and uses a wheelchair. Review of the resident's Face Sheet showed diagnoses of Dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), Anxiety Disorder, Osteoarthritis (a degeneration of joint cartilage and the underlying bone causing pain and stiffness), and Major Depressive Disorder. Review of the resident's care plan, updated 10/14/25, showed staff assessed the resident with pain, alteration in vision, anxiety, impaired cognition, and needed assistance with activities of daily living (ADL's). Review of the resident's care plan showed staff are directed to observe the resident for complaints of pain; observe for non-verbal signs and symptoms of pain (moaning, groaning, facial grimacing); explain procedures prior to performing to decrease anxiety or fear;</p>		