STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265566	A. Building B. Wing	09/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire Senior Living Warsaw	1609 Sunchase Drive Warsaw, MO 65355

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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 - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, facility staff failed to develop and implement complete policies and procedures for the inspection, testing and maintenance of the facility's water systems to inhibit the growth of waterborne pathogens and reduce the risk of an outbreak of Legionnaire's Disease (LD) (a serious type of pneumonia (lung infection) caused by Legionella bacteria, which places all residents at risk of exposure which could lead to illness. Facility staff failed to conduct an annual review of its Infection Prevention and Control Program (IPCP) and update their program, as necessary. Facility staff failed to implement Enhanced Barrier Precautions (EBP) for two residents (Resident#13 and Resident #49) out of four sampled residents who required EBP, and failed to provide colostomy (an external bag attached to a surgically created stoma on the abdomen to collect stool after the colon is redirected due to a medical condition) care in a manner to prevent the spread of infection during care for one resident (Resident #75) out of three sampled residents. The facility census was 81.1. Review of the Centers for Medicare and Medicaid Services (CMS) Quality, Safety and Oversight (QSO) 17-30, dated 06/02/17 and revised on 07/06/18, showed:-The bacterium Legionella can cause a serious type of pneumonia called Legionnaire's Disease in persons at risk. Those at risk include persons who are at least [AGE] years old, smokers, or those with underlying medical conditions such as chronic lung disease or immunosuppression. Outbreaks have been linked to poorly maintained water systems in buildings with large or complex water systems including hospitals and long-term care facilities. Transmission can occur via aerosols from devices such as showerheads, cooling towers, hot tubs, and decorative fountains.-Facilities must have water management plans and documentation that, at a minimum, ensure each facility: *Conducts a facility risk assessment to identify where Legionella and other opportunistic waterborne pathogens (e.g. Pseudomonas, Acinetobacter, Burkholderia, Stenotrophomonas, nontuberculous mycobacteria, and fungi) could grow and spread in the facility water system;*Develops and implements a water management program that considers the ASHRAE industry standard and the CDC toolkit;*Specifies testing protocols and acceptable ranges for control measures and document the results of testing and corrective actions taken when control limits are not maintained. Review of the facility's policy titled Water Management Program, dated February 19, 2020, showed:-A water management program shall be implemented to manage the risk of legionellosis for the facility's water system;-The program team shall include the administrator; maintenance director and Director of Nursing/Assistant Director of Nursing (DON/ADON) and the team shall have knowledge of the building water system design and water management as it relates to legionellosis;-Facility staff will survey their building and conduct a systematic risk analysis of hazardous water conditions in the building water systems and determine the locations in the system where control measures are required;-For each control measure at each control measure location the facility will determine the limits including but not limited to a maximum value, a minimum value, or a range of values within which a chemical or physical parameter must be monitored and maintained;-The following corrective actions are to be taken when monitoring indicates control parameters are outside of established control limits;--Coordinate with corporate chain of command--Issue a work order on the TELS (facility management software) work order system--Take (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	necessary actions to bring the measures back into control limits;--Document correction on work order;-The water management team is to review and confirm that all of the program elements are being implemented as designed during morning meeting after completion of preventative maintenance. Review showed the program did not contain facility specific risk areas or corrective actions to take when control measures were not within specified ranges. Review of the facility's TELS Water Management documentation for the period of September 2024 through September 2025 showed:-Nursing staff were to conduct a daily water flow test on all faucets, toilets and showers in resident care areas;-Maintenance staff were to conduct a daily water flow test on all faucets, toilets and showers in resident care areas;-Maintenance staff were directed to check pH and free chlorine levels every six months and make corrections per water management program. Review showed results of chlorine testing completed on 06/30/25 indicated 24 of 38 areas sampled were outside of the specified range. Review showed the records did not contain documentation of corrective action or review with water management team. During an interview on 09/03/25 at 2:45 the maintenance director said he/she was not aware of the facility specific Legionella related policies, and he/she was not familiar with the water management team. The maintenance director said he/she was not familiar with facility specific water management risk areas. The maintenance director said he/she followed TELS task lists related to the facility water systems. The maintenance director said all resident rooms, including showers which were not in use, were not being flushed on a routine basis. The maintenance director said he/she performed a one-minute water flush on two or three rooms per hall as part of bi-monthly room checks. The maintenance director said he/she did not run water in resident room showers if the shower contained resident belongings. The maintenance director said he/she checked the water pH, hardness and chlorine levels twice per year and would adjust the water softeners to adjust water hardness. The maintenance director said he/she was not aware of any corrective actions if chlorine levels were out of range.During an interview on 09/04/25 at 9:05 A.M., the DON said participation in the Water Management Program was part of his/her duties. The DON said since he/she started in the position about two weeks ago he/she was not familiar with the facility specifics of the program.During an interview on 09/04/25 at 12:15 P.M., the administrator said he/she was aware of the requirement to have a water management program but was not familiar with the specific components of the program. The administrator said the maintenance director is responsible for the facility water systems. 2. Review of the facility's policies titled, Infection Prevention and Control Manual, Hand Hygiene, dated 06/11/20, Nursing Procedure Manual, Colostomy/Ileostomy Care, dated 10/01/10, and Nursing Procedures Manual, Enhanced Barrier Precautions, dated 04/29/24, showed the policies did not contain documentation staff had reviewed and updated the polices as necessary. During an interview on 09/05/25 at 11:15 A.M., the administrator said the corporate office is responsible to review and update the policies on an annual basis. He/She said the corporate office sends an updated copy of the policies if something is revised. He/She said there is not an audit system in place to ensure the policies are reviewed and updated, since the corporate office is responsible to complete the annual review.3. Review of the facility's policy titled, Nursing Procedures Manual, Enhanced Barrier Precautions, dated 04/29/24, showed:-Enhanced Barrier Precautions (EBP) are an approach to the use of Personal Protective Equipment (PPE) as a strategy to decrease transmission of the Centers for Disease Control and Prevention (CDC)'s targeted multi-drug-resistant organisms (MDRO)s when contact precautions do not apply. -A sign indicating the EBP should be placed on the residents' door and if it is a semiprivate room, it should be labeled for which bed;-EBP requires the donning of a gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDRO's to staff hands and clothing;-EBP is employed while performing high contact resident care activities, including, transferring, providing hygiene, device care or use: urinary catheter (tube placed in the bladder to drain urine), feeding tube (tube placed in the stomach to deliver nutrition), tracheostomy (tube placed in the windpipe to ensure adequate oxygenation) and wound care.4. Review of Resident #13's (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Quarterly Minimum Data Set (MDS) a federally mandated assessment tool, dated 06/17/25 showed staff assessed the resident as cognitively intact, and had a tracheostomy and feeding tube. Observation on 09/02/25 at 12:42 P.M., showed the resident door with an EBP sign. Observation showed Licensed Practical Nurse (LPN) A suctioned the resident's tracheostomy tube and did not wear a gown. Observation on 09/05/25 at 9:43 A.M., showed LPN A administered medication through the resident's feeding tube and flushed the tube without a gown or gloves on. 5. Review of Resident #49's Annual MDS, dated [DATE], showed staff assessed the resident as cognitively intact, required substantial/maximal assistance for transfers, and had a surgical wound. Review of the resident's care plan, dated 08/18/25, showed staff documented the resident is on enhanced barrier precautions per wound care. The care plan showed staff documented the resident has skin breakdown.Review of the resident's Physician Order Summary (POS), dated 09/05/24, showed an order for EBP precautions due to the surgical incision. The POS showed an order to cleanse the surgical site with normal saline, pat dry, apply Medi honey (wound gel) to wound bed, and cover with bordered gauze dressing. The POS showed an order for a diabetic foot ulcer to cleanse the left foot with normal saline, pat dry, apply Medi honey to tissue, apply alginate (wound dressing) to wound bed, cover with abdominal pad, wrap with stretch gauze wrap and secure with tape.Observation on 09/03/25 at 10:31 A.M., showed the resident's room did not have EBP signage. Observation showed Certified Nurse Aide (CNA) C assisted the resident with a mechanical lift transfer and did not wear a gown or gloves. Observation on 09/4/25 at 10:30 A.M., showed the resident's room did not have EBP signage. CNA A, CNA B and CNA C assisted the resident with a mechanical lift transfer and did not wear gloves or a gown. During an interview on 09/04/25 at 10:32 A.M., the ADON said he/she did not see EBP signage on the door. The ADON said staff should have worn gloves and a gown during the transfers because the resident requires EBP. During an interview on 09/04/25 at 11:09 A.M., CNA D said there is not EBP signage on the resident's door and he/she did not know the resident required EBP. During an interview on 09/04/25 at 1:44 P.M., the Infection Preventionist (IP) said he/she is responsible to ensure EBP signage is visible to the resident, staff and visitors and the sign for the resident door had been posted but must have fallen off the door. The IP said he/she conducted an in-service about a month ago on the use of personal protective equipment (PPE). He/She said staff were provided a list of residents on EBP and are aware of what qualifies a resident to be placed on EBP, including a resident with a catheter, wounds, tracheotomy and/or feeding tube. The IP said staff are directed to use gloves and gowns when providing care for a resident on EBP. During an interview on 09/05/25 at 11:15 A.M., the administrator said staff put signs on the residents' doors that require EBP, and staff had been educated regarding EBP and when it is required. He/She said staff are directed to ask the nurse if they do not know what precautions the resident requires. He/She said the concern with not following EBP is the potential to spread infections. During an interview on 09/05/25 at 11:16 A.M., the DON said staff put signs on the residents' doors that require EBP. He/She said staff are knowledgeable regarding which residents require EBP by education from other staff, care plan and orders. The DON said if staff are unsure, they should ask the nurse. The DON said the concern with not following EBP precautions is the potential to spread infections. 6. Review of the facility's policy titled, Nursing Procedure Manual, Colostomy/Ileostomy (opening in the abdominal wall connecting the small outside the body) Care, dated 10/01/10, showed:-Wash hands thoroughly before and after providing care;-Remove drainage bag;-Apply clean drainage bag;-Discard soiled drainage bag and gloves into a disposable bag and appropriate receptacle;-Wash hands;-The policy did not contain direction for staff regarding a clean barrier for supplies and/or hand hygiene during care.Review of the facility's policy, Infection Prevention and Control Manual, Hand Hygiene, dated 06/11/20, showed staff were directed to:-To provide guidelines to employees for proper and appropriate hand washing techniques that will aide in the prevention of the transmission of infections;-Hand washing should be performed between procedures with resident based upon the principle that all blood, body fluids, secretions, excretions (except sweat), non-intact skin, and mucus membranes may contain transmissible infectious (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	agents;-Hand hygiene continues to be the primary means of preventing the transmission of infection. The following is a list of some situations that require hand hygiene before and after direct resident contact and after contact with resident mucous membranes and body fluids or excretions;-Consistent use by staff of proper hygienic practices and techniques is critical to preventing the spread of infections.7. Review of Resident #75's Quarterly MDS, dated [DATE], showed staff assessed the resident as cognitively intact and did not contain document the resident used a colostomy bag.Review of the resident's POS, dated 09/05/25, showed an order for colostomy care and to monitor the stoma.Review of the resident's care plan, dated 07/31/25, showed the resident has a colostomy related to colon cancer.Observation on 09/04/25 at 10:08 A.M., showed CNA C gathered the resident's colostomy care supplies and placed the supplies directly on the bed without a barrier. The CNA put on gloves, removed the resident's colostomy bag, provided colostomy care, and with the same soiled gloves, picked up the clean bandage, used a pair of scissors to cut the bandage to fit around stoma, applied the clean bandage to the colostomy bag and then applied the bag to the resident. The CNA removed his/her gloves, touched the resident's clothing and put the unused supplies on the resident's nightstand. The CNA picked up the dirty scissors and placed them on top of the medication cart. During an interview on 09/04/25 at 11:09 A.M., CNA C said he/she should have performed hand hygiene and glove changes after he/she removed the colostomy bag and bandage and before he/she touched the clean supplies. The CNA said he/she should not have placed clean supplies on the resident's bed, and he/she should have cleaned the scissors before placing them back on the cart. The CNA said he/she was training new staff and just did not think about it. The CNA said the issues is infection control and the possibility of transferring bacteria from resident to resident. During an interview on 09/04/25 at 1:44 P.M., the IP said staff are educated to perform hand hygiene when entering and exiting a resident room. The IP said staff should wash hands and apply clean gloves from all dirty to clean tasks. Colostomy care supplies should be placed on a clean surface or a barrier, and contaminated supplies should be thrown away or cleaned before leaving the resident's room. The concerns are spreading infection. Staff were recently in-serviced on infection control, including glove changes and hand hygiene.During an interview on 09/05/25 at 11:15 A.M., the administrator said staff should perform hand hygiene upon entering and exiting a resident's room. Staff should perform hand hygiene and glove changes after providing care, or encountering contaminated items, and before moving from a dirty to clean task. Colostomy care supplies should be placed on a clean surface or a protective barrier. Scissors should be cleaned after use in resident rooms. During an interview on 09/05/25 at 11:16 A.M., the DON said he/she expected staff to perform hand hygiene upon entering and exiting a resident's room, with glove changes, after providing care, after encountering contaminated items, and from dirty to clean tasks. Staff should have cleaned the scissors before leaving the resident's room and the clean supplies should have been placed on a barrier or clean surface.

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to manage his or her financial affairs. Based on interview and record review, facility staff failed to refund resident funds within 30 days of discharge for 16 residents (Resident #82, #83, #84, #85, #86, #87, #88, #89, #90, #91, #92, #93, #94, #95, #96, and #97) out of 50 sampled residents. The facility census was 81.1. Review of the facility's policy titled Resident Trust, dated October 2022, showed the facility will convey refunds upon death or discharge of a resident within 30 days or within the timeframe prescribed by the state regulation.2. Review of the facility's aging report (report showing outstanding invoices and balances), dated 09/03/25, showed the following residents had money in the facility's operating account:Resident Amount Held in Operating Account#82 $235.00#83 $400.00#84 $2,040.00#85 $1,938.00#86 $529.01#87 $174.40#88 $5,704.00#89 $520.00#90 $240.00#91 $4,512.39#92 $634.46#93 $20.00#94 $240.00 #95 $140.00#96 $20.00#97 $231.00Total $17, 578.26 3. During an interview on 09/04/25 at 02:00 P.M., the Financial Specialist Assistant (FSA) said he/she oversees resident funds and petty cash. He/She said there are discharged residents with delayed refunds, and he/she is trying to get caught up. He/She said some may be waiting for copay finalization and others are just behind.During an interview on 09/04/25 at 02:20 P.M., the Financial Specialist said he/she oversees the facility funds and is aware they are behind on processing resident refunds. He/She said the facility is behind because there is only one person processing refunds and with other business and summer vacations, it has gotten behind. He/She said it is not a result of extraordinary events.During an interview on 09/05/25 at 12:02 P.M., the Administrator said funds should be refunded to residents within two weeks to 30 days from discharge and after copays have been finalized. He/She said the Financial Specialist Assistant is responsible for conveying refunds. The Administrator said he/she knew they were behind on some refunds, but not aware some discharges dated as far back as December 2024. He/She said that is an excessive number of days.

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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, facility staff failed to ensure one resident (Resident #3), received an accurate insulin dosage, failed to accurately transcribe a verbal insulin order in the electronic medication administration record (eMAR) for one resident (Resident #36), and failed to document an appropriate diagnosis for psychotropic medication use for one resident (Resident #101). The census was 81.1. Review of the facility's policy titled General Dose Preparation and Medication Preparation, dated 01/01/13, showed staff are instructed to confirm the MAR reflects the most recent medication order and follow manufacturer medication administration guidelines. Review of the facility's policy titled Subcutaneous Injection with Lantus SoloStar Pen, dated 2009, showed staff are instructed to perform a safety test by priming the insulin pen with two units of insulin to remove air bubbles and ensure the needle and pen are working properly.Review of the manufacturer's guidelines for Lantus insulin pen Solostar, dated 2022, instructed users to perform a safety check after attaching the needle to expel trapped air by dialing a test dose of two units of insulin. Press the injection button and check to see that insulin comes out of the needle. If no insulin comes out, repeat the test two more times. If no insulin comes out, change the needle. Always perform the safety test before each injection and never use the pen if no insulin comes out after using a second needle. 2. Review of Resident # 3's Quarterly Minimum Data Set (MDS) a federally mandated assessment tool, dated 08/01/25, showed staff assessed the resident had a diagnosis of diabetes mellitus and received insulin. Observation on 09/05/25 at 8:20 A.M. showed Licensed Practical Nurse (LPN) A attached a needle to the resident's insulin pen, primed the needle with two units of insulin, removed the primed needle, applied a new needle and administered the resident's insulin. The LPN did not prime the new needle before he/she administered the resident's insulin During an interview on 09/05/25 at 8:28 A.M., LPN A said he/she was trained to replace the insulin pen needle after priming. He/She said the purpose of priming the needle was to expel air. LPN A said he/she never questioned it, but it is not good practice. During an interview on 09/05/25 at 9:00 A.M., the Assistant Director of Nursing (ADON) said insulin pen needles should not be changed in between priming, because that defeats the purpose of priming the needle. During an interview on 09/05/25 at 10:15 A.M., the Director of Nursing (DON) said the purpose of priming insulin pen needles is to dispel air bubbles. He/She said changing a needle after it has been primed and applying a new needle is not standard practice. The DON said the risk is dispensing an inaccurate dose of insulin.During an interview on 09/05/25 at 11:16 A.M., the administrator said she believes insulin administration is part of the facility staffs annual competency testing. He/She said not properly priming the insulin needles could cause inaccurate dosing.3. Review of the facility's policy titled Verbal and Facsimile Orders, dated 10/01/10, showed staff are instructed to enter verbal orders in the medical record and read the order back to the physician to ensure accuracy.4. Review of Resident # 36's Annual MDS, dated [DATE], showed staff assessed the resident had a diagnosis of diabetes mellitus and received insulinObservation on 09/05/25 at 08:58 A.M. showed LPN B administered 17 units of insulin to the resident.Review of the resident's electronic physician order set (POS) showed an order dated 07/02/25 for 20 units of insulin aspart (fast acting insulin). A special instruction note read: Administer 20 units after meals, hold if he/she eats less than 60%. Review of the resident's paper POS, dated 07/15/25, showed an order for 17 units of insulin aspart. A special instruction note read: Administer 20 units after meals, hold if he/she eats less than 60%. During an interview on 09/05/2025 at 9:18 A.M. LPN B said a verbal order was received on 07/15/25 that changed the insulin dose from 20 units to 17 units. LPN B said he/she had not noticed the special instructions to give 20 units was not removed when the order changed. LPN B said the resident's insulin order had two different dosages. He/She said there is not a progress note from the time of the order, and it was entered directly into the electronic record. During an interview on 09/05/25 at 10:15 A.M., the Director of Nursing (DON) said new medication orders are (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reviewed by the Interdisciplinary Team (IDT). The DON said a progress note should be written when verbal orders are received by the nurse. The DON said he/she expects orders to be reviewed by the nurse for accuracy and prior to medication administration.During an interview on 09/05/25 at 11:16 A.M., the administrator said medication orders are documented in the computer system by the nurses when received by a physician. He/She said nurses are expected to accurately transcribe and review medication orders, and any errors should be noticed in the morning IDT meeting.4. Review of Resident #101's Face Sheet, undated, showed the resident admitted to the facility on [DATE].Review of the resident's POS, dated 09/05/25, showed an order for 0.5 milligrams (mg) of Lorazepam (used to treat anxiety) for the treatment of depression. The POS did not contain documentation of an anxiety diagnosis.During an interview on 09/04/25 at 1:44 P.M., the Infection Preventionist (IP) said staff are required to obtain an appropriate diagnosis for prescribed medication. He/She said staff are directed to contact the doctor if there is not an appropriate diagnosis.During an interview on 09/05/25 at 11:15 A.M., the administrator said the IDT team reviews medications to verify appropriate diagnoses, when a resident is admitted to the facility. He/She said the resident was admitted from the hospital with a physician's order for Lorazepam. He/She said there is not an appropriate diagnosis for the use of the medication, but staff wanted to keep the resident on the medication until he/she was acclimated to the facility. He/She said staff scheduled an upcoming appointment for the resident with a psychiatrist.During an interview on 09/05/25 at 11:16 A.M., the DON said when a resident is admitted to the facility, the IDT team reviews their medication list to determine if there is an appropriate diagnosis for each prescribed medication. He/She said the resident was admitted to the facility from the hospital with a prescription for Lorazepam. He/She said he/she knew the resident did not have an appropriate diagnosis for the medication, but staff did not want to discontinue the medication until the resident became acclimated to the facility. He/She said staff scheduled an appointment for the resident with a psychiatrist for the upcoming week.