STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265625	A. Building B. Wing	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire Senior Living New Florence	515 Picnic Street New Florence, MO 63363

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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. Based on interview and record review, facility staff failed to implement an Antibiotic Stewardship Program with antibiotic use protocols and a system to monitor and track antibiotic use within the facility. The facility census was 50.1. Review of the facility's policy titled, Antibiotic Stewardship, undated, showed the purpose is to develop and implement protocols to optimize the treatment of infections by ensuring the residents who require an antibiotic, are prescribed the appropriate antibiotic. Reduced the risk of adverse events, including the development of antibiotic-resistant organisms, from unnecessary or inappropriate antibiotic use. Develop, promote, and implement a facility wide system to monitor the use of antibiotics.Review of the facility's antibiotic stewardship program showed staff did not have a process in place to track and trend antibiotic usage.During an interview on 09/25/25 at 8:05 A.M., the administrator said the Assistant Director of Nursing (ADON) started a few months ago along with her and the Director of Nursing. The ADON was the infection preventionist and was to work on getting a process started for the Antibiotic Stewardship. The administrator said the ADON left September 9th, and it is still unknown what has or hasn't been done because he/she did not leave any of the information at the facility.

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265625	A. Building B. Wing	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire Senior Living New Florence	515 Picnic Street New Florence, MO 63363

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 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on interview and record review, the facility staff failed to designate one or more individuals with specialized training in Infection Prevention and Control (IPC) as the Infection Preventionist (IP) for the facility's infection prevention and control program. The census was 50. 1. Review of the facility's Infection Preventionist (IP) Policy, undated, directed staff to designate a qualitied individual (s) to be responsible for implanting programs and activities to prevent and control infections. During an interview on 09/25/25 at 8:05 A.M., the administrator said the Assistant Director of Nursing (ADON) was the infection preventionist and left the facility September 9, 2025. The administrator said at this time the facility does not have an IP.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265625	A. Building B. Wing	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire Senior Living New Florence	515 Picnic Street New Florence, MO 63363

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility staff failed to provide a clean, homelike and comfortable environment when staff failed maintain resident rooms, common areas, medical device equipment and the exterior of the building clean and in good repair. Facility census was 50.1.Review of the facility's External Environmental Services policy, dated 01/30/2024, directed staff to keep building exterior in good repair.2.Review of the maintenance records showed they did not contain documentation related to spa remodels.3.Review of the proposal for roof repairs, dated 08/12/25, showed the proposal did not contain approval signatures.4. Observation on 09/23/25 during the Life Safety Code tour showed:-The mansard roof on the north side of the facility contained multiple missing shingles which exposed the wood decking. Observation showed rotted decking material and two holes which exposed the attic space;-Two wall corners in the 100 hall spa behind the toilet contained cracks which spanned from the floor to the ceiling. Observation showed there was a gap between the tile floor and the baseboard behind the toilet;-The wall in resident room [ROOM NUMBER] contained a large rectangular hole which exposed the wall cavity below the resident's desk.During an interview on 09/24/25 at 11:45 A.M., the maintenance director said he/she was responsible for ensuring the facility interior and exterior repairs are completed. The maintenance director said he/she was aware of the holes in the roof, the cracks in the spa walls and the hole in resident room [ROOM NUMBER]. The maintenance director said the facility was under new ownership since May and he/she was working with corporate staff to get roof repaired and have two spas remodeled. The maintenance director said he/she did not know the status of repair or remodel plans. The maintenance director said the hole in resident room [ROOM NUMBER] had been there for quite a while but he/she had not had a chance to make repairs.During an interview on 09/24/25 at 2:30 P.M., the administrator said the maintenance director was responsible for keeping the facility in good repair. The administrator said he/she was aware of the roofing and spa issues but did not know the status of bids or repairs since corporate staff were working on these issues. The administrator said he/she was not aware of the hole in resident room [ROOM NUMBER].

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265625	A. Building B. Wing	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire Senior Living New Florence	515 Picnic Street New Florence, MO 63363

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 - Some	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** Based on observation, interview, and record review, facility staff failed to complete an entrapment assessment for two residents (Resident #2 and #38) of two sampled residents with bed rails. The facility census was 50. 1. Review of the facility's policy titled, Bed/Assist Bars Use in Long-Term Care, dated 09/17/25, showed staff are directed: -Nursing/Therapy staff must perform a risk assessment prior to implementation that considers entrapment risk;-Findings and rationale must be documented in the resident's care plan;-Ensure proper positioning to minimize entrapment and injury risk. 2. Review of Resident #2's comprehensive minimum data set (MDS), a federally mandated assessment tool, dated 06/26/25, showed staff assessed the resident as:-Cognitively intact;-Diagnoses of a seizure disorder or epilepsy;-Bed rails not used as restraint in bed.Observation on 09/23/25 at 2:42 P.M., showed the resident in bed with bilateral U bars in the upright position. Review of the resident's medical record did not contain an entrapment assessment.3. Review of Resident #38's comprehensive MDS, dated [DATE], showed staff assessed the resident as: -Cognitively intact;-Diagnoses of multiple sclerosis;-Impairments on both sides of upper and lower extremities;-Bed rails not used as restraints in bed.Observation on 09/24/25 at 8:24 A.M., showed the resident in bed with one quarter length bed rail in the upright position. Observation on 09/25/25 at 7:50 A.M., showed the resident in bed with one quarter length bed rail in the upright position.Review of the resident's medical record did not contain an entrapment assessment.During an interview on 09/25/25 at 12:45 P.M., the Maintenance Director said he/she is responsible for completing entrapment assessments on bed rails and should complete the entrapment assessments for any new bed rails and then two times a year after the initial installation. The Maintenance Director said he/she completed entrapment assessments on the resident's bed rails, but did not document the assessments. The Maintenance Director said he/she should have documented the entrapment assessments and said he/she got busy which is why they were missed being documented. During an interview on 09/25/25 at 12:55 P.M., the administrator said the Maintenance Director is responsible for completing entrapment assessments on bed rails to ensure there is nothing loose or to ensure there are no gaps. The administrator said an entrapment assessment should be completed when installing a new bed rail and then he/she would expect for the bed rail to be checked monthly.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265625	A. Building B. Wing	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire Senior Living New Florence	515 Picnic Street New Florence, MO 63363

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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on interview and record review, the facility staff failed to develop and implement an effective Quality Assurance (QA)/Quality Assurance Performance Improvement (QAPI) program which included documentation and implementation of on-going systemic issues with resolution. The facility census was 50.1. Review of the facility's Quality Assurance and Performance Improvement Plan, undated, showed, it is the purpose of this facility-wide performance improvement process to include identifying and implementing opportunities to improve the quality of resident care and quality of life, as well as other measures of organizational performance. Meeting quarterly with key personal attending to coordinate this program. Review of the Performance Improvement Program, dated 09/03/25, showed, area of concern: QAPI has not been previously done.Review of the facility's records showed staff did not provide documentation of a QAPI/QA program.During an interview on 09/25/25 at 7:59 A.M., the administrator said there is no information on a QAPI/QA program to provide, and the facility is going to have to start this from scratch.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265625	A. Building B. Wing	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire Senior Living New Florence	515 Picnic Street New Florence, MO 63363

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 - Some	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. Staff failed to ensure the two-step purified protein derivative (PPD) (skin test for tuberculosis bacteria (TB)) was completed in accordance with their policy and on file for five employees (Dietary D, Certified Medication Technician (CMT) E, Housekeeper F, Social Services, and Certified Nursing Assistant (CNA) G) out of ten employee files reviewed. Facility staff failed to ensure all residents were screened for Tuberculosis (TB) (a potentially serious infectious bacterial disease that mainly affects the lungs) when staff failed to ensure a two-step purified protein derivative (PPD) (skin test for TB) and/or annual PPD tests were completed and documented as per the facility policy for three residents (#2, #14, and #18) out of six sampled residents. Facility staff failed to provide wound care in a manner to reduce the risk of infection for two residents, (Residents #6 and #30) out of three sampled residents. The facility census was 50.1. 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 Water Management and Legionella Risk Reduction policy, reviewed 2023, showed:-At least annually, the facility will conduct a Water Program Review;-At the time of the Water Management Review the Water Management Program Team will update the process flow diagram, associated control points, control limits and corrective actions if needed;-Control measures and limits should be established for each control point;-Facility specific control points for hazardous conditions included ice machines, the main kitchen, the satellite kitchen, sinks, tubs, showers and toilets.Review of the facility's Water Program Review dated, 06/19/25, showed the assessment did not contain any additional details. Review showed the facility specific program did not contain control measures or control limits for the identified hazardous conditions control points.Observation on 09/23/25, during the facility tour showed the facility equipped with multiple spas, an unused satellite kitchen and multiple showers in resident bathrooms.Observation on 09/22/2025 at 11:02 A.M., showed room [ROOM NUMBER] bathroom sink with water brown. During an interview on 09/24/25 at 11:25 A.M., Housekeeper C said he/she ran water in resident rooms daily for about 30 seconds. Housekeeper C said he/she had seen brown water in the past in sinks that were not used regularly.During an interview on 09/24/25 at 11:45 AM the maintenance director said he/she and the water committee, which also included the administrator and dietary manager, were responsible for the water management program. The maintenance director said he/she had reviewed Centers for Disease Control (CDC) documents (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265625	A. Building B. Wing	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire Senior Living New Florence	515 Picnic Street New Florence, MO 63363

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 - Some	describing risks and it was his/her understanding there were no identified risks in the facility. The maintenance director said housekeeping staff ran the water for two minutes in every room monthly, but it was not documented. The maintenance director said the water should not be brown.During an interview on 09/24/25 at 2:30 PM the administrator said corporate staff were responsible for establishing the water management program. The administrator said he/she just started about one month ago and had not reviewed the water management program in depth. The administrator said the program should include facility specific control measures and corrective actions for identified potentially hazardous conditions.2. Review of the facility's policy titled, Employee Tuberculosis Screening, dated 01/30/24, showed the following guidance:- Tuberculosis screening is a part of the pre-employment medical examination and in general, all employees in this long-term care facility are to comply with established tuberculosis screening procedures;- A two-step Mantoux test (used to determine if a person has been infected with TB) is given unless the employee has documentation of a previous positive reaction;- Upon employment, the employee will receive 0.1 milliliters of Tuberculin Units of PPD which is considered step one;- The employee is instructed to return for the TB reaction reading in 48 to 72 hours. The employee is not to have any resident contact until after the results of the first skin test have been obtained;- If the first skin test is negative, a second skin test is given within 14 days after the original test. 3. Review of Dietary D's employee file showed:- Hire date of 05/01/25;- The file did not contain documentation the second PPD administered.4. Review of CMT E's employee file showed:- Hire date of 08/14/25;- The file did not contain documentation of a PPD test.5. Review of Housekeeper F's employee file showed:- Hire date of 05/01/25;- The first PPD administered on 08/20/25 and the second PPD administered 08/29/25, after the employee's hire date. 6. Review of Social Services employee file showed:- Hire date 06/20/25;- The first PPD administered on 08/21/25 and did not contain a read date;- The file did not contain documentation the second PPD administered.7. Review of CNA G's employee file showed:- Hire date 08/12/25;- The file did not contain documentation the second PPD administered. 8. During an interview on 09/25/25 at 1:10 P.M., the Director of Nursing (DON) said he/she started working at the facility a month ago and is currently responsible for employee PPD testing. The DON said the facility previously had an assistant DON who was responsible for employee PPD testing upon hire and annually. The DON said he/she has had problems finding employee PPD records since working at the facility. The DON said when a new employee gets hired, he/she would expect for the employee to receive the two-step PPD test prior to working on the floor with residents and would expect for the employee to receive a PPD screening annually. 9. During an interview on 09/25/25 at 1:15 P.M., the administrator said he/she expects new employees to receive the two-step PPD test prior to working on the floor with residents and would expect for the employee to receive a PPD screening annually.10. Review of the facility policy Mantoux testing - Residents (Tuberculosis Screening), undated, showed the policy directs staff as follows:-Residents will be screened for tuberculosis infections upon their admission to the facility and at intervals appropriate for the regional;-Upon admission, residents/guests should receive the PPD two-step screening. If screening was done by the transferring hospital, it must have occurred within 30 days prior to nursing home admission. The facility should obtain documentation of the results of X-Rays and PPD tests.11. Review of Resident #2's medical record showed an admission date of 06/02/25. Review showed the immunization record did not contain documentation a first or second step TB test administered. 12. Review of Resident #14's medical record showed an admission date of 06/09/25. Review showed the immunization record did not contain documentation a first or second step TB test administered.13. Review of Resident #18's medical record showed an admission date of 02/06/25. Review showed the immunization record did not contain documentation a first or second step TB test administered.During an interview on 09/25/25 at 1:43 P.M., the DON said a 2 step TB should be completed on admission and an annual screening should be done. The DON said he/she is not sure why they weren't done, but the new infection preventionist will be responsible to do this process moving forward. During an interview on 09/25/25 at 8:05 A.M., the administrator said she is (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265625	A. Building B. Wing	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire Senior Living New Florence	515 Picnic Street New Florence, MO 63363

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 - Some	not sure why TB's are not completed. She said TB's are currently top priority right now, because it was found that records were not being kept up to date. The administrator said if the TB's are done, they would be uploaded into the system.14. Review of the Facility's Hand Hygiene policy, undated, showed the following:-Staff will follow the facility's established hand hygiene procedures to prevent the spread of infection and disease to other staff, residents, and visitors;-Hands should be washed for at least twenty seconds using soap and water under the following conditions:--Before having direct contact with a resident;--After having direct contact with a resident;--Before providing invasive procedures;--Before handling clean or soiled dressings, gauze pads, etc.; --After handling used dressings, contaminated equipment, etc.;--After contact with blood, bodily fluids, excretions, secretions, mucous membranes, or non-intact skin;--After handling items potentially contaminated with blood, body fluids, excretions, or secretions;--Before putting on gloves;--After removing gloves;-Hand sanitizers containing at least 60% alcohol maybe used when soap and water is not readily available.15. Review of Resident #6's quarterly Minimum Data Set (MDS), a federally mandated resident assessment tool, dated 9/15/25 showed staff assessed the resident as follows:-Cognitively intact;-At risk for developing pressure ulcers/injuries;-One unhealed stage II pressure injury.Review of the residents Physician order sheet (POS), date 09/24/25, showed staff are directed to apply skin prep to residents right heal for skin protection two times a day for wound/skin management.Review of the resident's care plan, dated 7/10/25, showed the resident is at risk for impairment to skin integrity due to incontinence and requiring assistance with activities of daily living (ADLs).Observation on 09/24/2025 at 12:04 P.M., Registered Nurse (RN) A entered the resident's room to perform right heel wound care. He/She placed a gown and gloves on, placed a barrier, and cleaned the wound with skin prep. He/She left the residents room with the gown and gloves on, went to the treatment cart, removed gloves, replaced without hand hygiene, grabbed gauze from the cart, and came back in the resident's room. He/She cleaned the resident's bloody right toe. He/She removed gloves and replaced them without performing hand hygiene.16. Review of Resident #30's quarterly MDS, dated [DATE] showed staff assessed the resident as cognitively intact, has a diagnosis of heart failure and diabetes mellitus.Review of the resident's POS, dated 09/2025, showed the following:-Cleanse left lower leg blister with wound cleanser and dry gauze, apply wound gel and Abdominal pad, wrap with kerlix wrap every day/shift and as needed for wound/skin management;-Cleanse right lower leg blister with wound cleanser and dry gauze, apply wound gel and Abdominal pad, wrap with kerlix wrap every day/shift and as needed for wound/skin management.Observation on 09/24/2025 at 11:07 A.M., RN A entered the resident's room to perform wound care on bilateral lower leg wounds. He/She placed on a gown and gloves. He/she placed the barrier and clean wound supplies on the bed between the resident's legs. He/She placed the residents bandaged legs on top of the clean barrier with the clean supplies in the middle between the resident legs. He/She cut the right lower leg bandage off the resident's leg with scissors and placed the soiled bandage, scissors on the clean barrier and placed the uncovered leg wound on the clean barrier. With the same soiled gloves, RN A removed the bandage from the left leg with scissors and wound cleaner, discarded the bandages and scissors on top of the clean barrier and then placed the uncovered leg wound on the top of the clean barrier. RN A opened the clean supplies and then placed the open supplies back on the clean barrier. He/She left the residents room with his/her gown and gloves on. He/She removed his/her gloves in the hallway and then removed two tongue suppressors from the treatment cart. He/She replaced his/her gloves without performing hand hygiene. He/She used a tongue suppressor to apply the resident's cream to the wound on the left side, placed the abdominal pad on the wound, and then placed the leg back on the same barrier. He/She then lifted the resident's leg, picked up the gauze from the barrier, and wrapped the left leg with the roll of gauze. He/She removed his/her gloves and replaced his/her gloves without performing hand hygiene. He/She cleans the right wound with wound cleaner, used the tongue suppressor to apply the cream to the right leg wound, placed the abdominal pad on the wound and then placed the leg back down on the barrier. With (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265625	A. Building B. Wing	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire Senior Living New Florence	515 Picnic Street New Florence, MO 63363

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 - Some	the same gloves he/she wraps gauze around the leg. He/She put the soiled scissors and placed them in the top drawer of his/her treatment cart without cleaning or disinfecting them.During an interview on 09/25/25 at 1:09 P.M., the DON said his/her expectation is that staff clean their hands between clean and dirty tasks, before applying gloves, any times gloves are removed, and any time gloves become soiled or are in contact with fluids. He/She said he/she expects staff to use a clean barrier for wound care supplies and expects staff to place dirty bandages, used supplies and trash during wound care in a trash bag. He/She said trash and/or used wound care supplies should never be placed on clean barriers. He/She said staff should remove PPE before exiting a resident's room and should not wear dirty gloves/gowns in the hallways. He/She said hand hygiene and glove changes during would care are important to prevent the spread of infections. He/She said he/she expects staff to provide care for each wound individually with clean gloves to prevent cross contamination.During an interview on 09/25/25 at 1:15 P.M., the Administrator said he/she expects staff to change gloves and perform hand hygiene any time they go from one task to another or from clean to dirty tasks. He/She said residents with multiple wounds should have care completed separately to prevent cross contamination. He/She said personal protective equipment (PPE) should be removed and hand hygiene performed before exiting a resident room. He/She said he/she expects staff to place all wound care supplies on a clean barrier and all used items should be placed in a trash bag and not on the clean surface of the barrier. He/She said this is to help prevent the spread of infections. During an interview on 10/02/25 at 10:02 A.M., RN A said staff are expected to wash hands before starting a wound treatment and should change gloves and wash hands when going from dirty to clean tasks and should remove gloves and wash hands before leaving the residents room. He/She said clean barriers help prevent the spread of infection. He/She said he/she should have kept the barrier clean and all used supply items should have been placed in a trash bag. He/She said he/she typically uses a trash bag and does not place dirty items on his/her clean barrier, but didn't use one during the wound care because he/she forgot it in the treatment cart. He/She said dirty or used items can increase the risk for infection or the transfer of bacteria. He/She said residents with multiple wounds should have wounds treated separate as per the orders. He/She said the mistakes made during wound care were due to nerves.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265625	A. Building B. Wing	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire Senior Living New Florence	515 Picnic Street New Florence, MO 63363

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 0628 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, facility staff failed to provide written information to the resident and/or the resident's representative of the bed hold policy at the time of transfer to the hospital for three residents (Resident #22, #38, and #49) out of three sampled residents. The facility census was 50.1. Review of the facility's policy titled, Bed Hold Policy Guidelines, undated, showed the facility will notify residents and/or their representative of the bed hold policy guidelines. The bed hold notification shall be given upon admission to the facility, at the time of transfer to the hospital or leave, and at the time of non-covered therapeutic leave. 2. Review of Resident #22's medical record showed staff documented the resident discharged from the facility to the hospital on [DATE] and returned on 05/01/25. The medical record did not contain documentation staff issued a bed hold upon discharge to the resident or the resident's responsible party. 3. Review of Resident #38's medical record showed staff documented the resident discharged from the facility to the hospital on [DATE] and returned on 08/12/25. The medical record did not contain documentation staff issued a bed hold upon discharge to the resident or the resident's responsible party.4. Review of Resident #49's medical record showed staff documented the resident discharged from the facility to the hospital on [DATE] and did not document a return date. The medical record did not contain documentation staff issued a bed hold upon discharge to the resident or the resident's responsible party.5. During an interview on 9/25/25 at 1:00 P.M., the Director of Nursing (DON) said he/she started at the facility about a month ago and is uncertain about the facility's bed hold policy.During an interview on 09/25/25 1:02 P.M., the administrator said when a resident is discharged to the hospital or therapeutic leave, the discharging nurse is responsible to provide the bed hold policy and obtain the resident's or residents representative signature. The administrator said he/she is not sure if this process is currently happening or not. The administrator said he/she would expect for the resident or resident's representative to be notified of the facility's bed hold policy each time a resident is discharged to the hospital.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265625	A. Building B. Wing	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire Senior Living New Florence	515 Picnic Street New Florence, MO 63363

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 0656 Level of Harm - Potential for minimal harm Residents Affected - Many	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, facility staff failed to develop and implement a comprehensive person-centered care plan to reflect the care needs for three residents (Resident #2, #30, and #41) out of 13 sampled residents. The facility census was 50.1. Review of the facility's policy titled, Care Plan Policy, undated, the care plan is designed to identify each resident's strengths, needs, goals, and preferences and to guide the delivery of quality, coordinated care that promotes the highest practicable physical, mental, and psychosocial well-being. Review showed:-Care plans shall be written in clear, measurable, and actionable terms, identifying specific interventions and goals;-Care plans shall be reviewed and revised quarterly, annually, and with any significant change in status;-Revisions must reflect changes in resident condition, treatment, preferences, or goals;-All updates, reviews, and revisions must be dated, timed, signed, and clearly documented.2. Review of Resident #2's admission Minimum Data Set (MDS), a federally mandated resident assessment tool, dated 06/09/25, showed staff assessed the resident as cognitively intact and receives hospice services.Review of the resident's Physician's Order sheet (POS), dated 06/09/25, showed an order for hospice services.Review of the resident's care plan, dated 09/16/25, showed the care plan did not contain documentation of the resident's Hospice care. 3. Review of Resident #30's Quarterly MDS, dated [DATE], showed staff assessed the resident as follows:-Cognitively intact;-Has an indwelling catheter (tube inserted int the urinary tract to drain urine form the bladder).Review of the resident's care plan, dated 07/24/25, showed the care plan did not contain documentation of the resident's catheter.4. Review of Resident #41's Quarterly MDS, dated [DATE], showed staff assessed the resident as severe cognitive impairment and does not receive hospice services.Review of the resident's POS, dated 09/10/25, showed an order for hospice services.Review of the resident's care plan, dated 06/18/25, showed the care plan did not contain documentation of the resident's Hospice care. 5. During an interview on 09/25/25 at 1:25 P.M., the Director of Nursing (DON) said hospice residents come with their own set of care, so it is important this is care planned. The DON said resident catheter should be care planned also, and is important staff know for infection prevention and care. During an interview on 09/25/25 at 1:29 P.M., the administrator said the care plan coordinator from another home is responsible for care plans and the care plan meetings. He/She comes to the building two to three times a week. The administrator said he/she has been covering the care plan process for as long as she has been in the building. The administrator was not aware these things were not on the resident's care plan. During an interview on 09/29/25 at 9:52 A.M., the care plan coordinator said he/she works approximately one and half days each week. The care plan coordinator said hospice should be included on the resident's care plans, along with any changes to a resident using a catheter, whether the catheter is new or removed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265625	A. Building B. Wing	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire Senior Living New Florence	515 Picnic Street New Florence, MO 63363

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 0657 Level of Harm - Potential for minimal harm Residents Affected - Many	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, facility staff failed to ensure care plans were reviewed and revised with changes in the resident's needs for seven residents (Resident #5, #14, #16, #19, #23, #38 and #41) out of 13 sampled residents. The facility census was 50.R 1. Review of the facility's policy titled, Care Plan Policy undated, showed the care plan is designed to identify each resident's strengths, needs, goals and preferences and to guide the delivery of quality, coordinated care that promotes the highest practicable physical, mental, and psychosocial well-being. Review showed:-Care plans shall be written in clear, measurable, and actionable terms, identifying specific interventions and goals;-Care plans shall be reviewed and revised quarterly, annually, and with any significant change in status;-Revisions must reflect changes in resident condition, treatment, preferences, or goals;-All updates, reviews, and revisions must be dated, timed, signed, and clearly documented.2. Review of Resident #5's Annual minimal data set (MDS), a federally mandated assessment tool, dated 08/12/25, showed staff assessed the resident as follow:-Cognitively intact;-Used a wheelchair,-Upper extremity impairments on both sides;-Lower extremity impairments not assessed. Review of the resident's progress notes, dated 06/01/25, showed staff documented the resident had an unwitnessed fall.Review of the resident's progress notes, dated 06/16/25, showed staff documented the resident had an unwitnessed fall.Review of the resident's care plan, dated 07/10/25, showed staff assessed the resident at risk for falls related to history of falls. Review showed the care plan did not contain new interventions after each of the resident's falls. 3. Review of Resident #14's Quarterly MDS, dated [DATE], showed staff assessed the resident as follows:-Cognition moderately impaired;-On hospice care. Review of the resident's Outside the Hospital Do-Not-Resuscitate (DNR) Order, dated 06/02/25, showed the residents representative signed the order for the resident to be a DNR.Review of the resident's physician order sheet (POS), dated September 2025, showed the resident with an DNR order.Review of the resident's care plan, dated 07/05/2025, showed staff assessed the resident to remain a full code. Review showed the residents care plan did not reflect the residents correct advanced directives. During an interview on 09/25/25 at 1:35 P.M., the Director of Nursing (DON) said patient centered out comes, change in conditions and personal needs should be on resident's care plans. During an interview on 09/25/25 at 1:39 P.M., the administrator said the care plan coordinator from another facility is responsible for care plans at this time and has been covering this area since she has been here as the administrator. During an interview on 09/29/25 at 9:52 A.M., the care plan coordinator said he/she works approximately one and half days each week in the facility. He/She said the residents care plan should list the correct advanced directives for a resident and said if he/she does not have a residents DNR orders at the time of admission, then the resident will be listed as a full code. The care plan coordinator said he/she should have updated the residents care plan once the DNR orders were confirmed. 4. Review of Resident #16's Annual MDS, dated [DATE], showed staff assessed the resident as follows: -Cognition not assessed;-Did not contain documentation of a fall since admission. Review of the resident's nursing progress notes, 07/21/25, showed staff documented the resident had an unwitnessed fall. Review of the resident's nursing progress notes, 08/11/25, showed staff documented the resident had an unwitnessed fall. Review of the resident's care plan, last revised 04/09/25, showed staff did not review or revise the care plan to reflect the resident falls or fall interventions. 5. Review of Resident #19's Quarterly MDS, dated [DATE], showed staff assessed the resident as follows: -Moderately cognitively impaired;-Two or more falls since admission. Review of the resident's nursing progress notes, 06/21/25, showed staff documented the resident had an unwitnessed fall. Review of the resident's nursing progress notes, 07/14/25, showed staff documented the resident had an unwitnessed fall. Review of the resident's nursing progress notes, 08/16/25, showed staff documented the resident had an unwitnessed fall. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265625	A. Building B. Wing	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire Senior Living New Florence	515 Picnic Street New Florence, MO 63363

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 0657 Level of Harm - Potential for minimal harm Residents Affected - Many	Review of the resident's nursing progress notes, 08/29/25, showed staff documented the resident had an unwitnessed fall. Review of the resident's care plan, last revised 04/07/25, showed staff did not review or revise the care plan to reflect the resident falls or fall interventions. 6. Review of Resident #23's Quarterly MDS, dated [DATE], showed staff assessed the resident as follows: -Severe cognitive impairment;-One sided impairment to the upper and lower extremity;-Diagnosis of a stroke and complete paralysis and partial weakness.Review of the resident's progress notes, dated 08/30/25, showed the resident had an unwitnessed fall that caused bruising to right knee, right ankle, and down the outside of his/her right calf.Review of the resident's care plan, dated 06/18/25, showed staff did not review or revise the care plan to reflect the resident falls or fall interventions7. Review of Resident #38's significant change MDS, dated [DATE], showed staff assessed the resident as follows: -Cognitively intact;-Used an indwelling catheter.Review of the resident's nursing progress notes, dated 08/31/25, showed staff documented the residents foley catheter removed.During an interview on 09/22/25 at 2:50 P.M., the resident said he/she used to have a catheter but no longer has one. Review of the resident's care plan, dated 08/01/25, showed the resident at risk for infection related to a urinary catheter and the resident will remain free from catheter-related trauma through review date. Review showed staff did not update the care plan to reflect the removal of the residents foley catheter.During an interview on 09/25/25 at 1:35 P.M., the DON said patient centered out comes, change in conditions and personal needs should be on resident's care plans. During an interview on 09/25/25 at 1:39 P.M., the administrator said the care plan coordinator from another facility is responsible for care plans at this time and has been covering this area since she has been here as the administrator. During an interview on 09/29/25 at 9:52 A.M., the care plan coordinator said he/she works approximately one and half days each week in the facility. The care plan coordinator said any changes to a resident using a catheter, whether the catheter is new or removed should be listed on the care. 8. Review of Resident #41's Quarterly MDS, dated [DATE], showed staff assessed the resident as follows;-Severe cognitive impairment;-Used a wheelchair;-Moderate assistance with toileting, showering/bathing, lower body dressing, sit to stand, and chair/bed-to-chair transfer;-Diagnosis of dementia and Parkinson's Disease (A disorder of the central nervous system that affects movement, often including tremors, slow movement, stiffness, and loss of balance).Review of the resident's nursing progress notes, 07/30/25, showed staff documented the resident had an unwitnessed fall. Review of the resident's nursing progress notes, 08/04/25, showed staff documented the resident had an unwitnessed fall. Review of the resident's nursing progress notes, 08/07/25, showed staff documented the resident had an unwitnessed fall. Review of the resident's nursing progress notes, 08/22/25, showed staff documented the resident had an unwitnessed fall. Review of the resident's nursing progress notes, 09/18/25, showed staff documented the resident had an unwitnessed fall. Review of the Resident's Care plan, dated 07/10/25, showed staff did not review or revise the care plan to reflect the resident falls or fall interventions.During an interview on 09/25/25 at 1:35 P.M., the DON said he/she would expect safety interventions and detailed interventions for falls to be on the resident's care plan. The DON said patient centered out comes, change in conditions and personal needs should be on resident's care plans.During an interview on 09/25/25 at 1:39 P.M., the administrator said the residents care plan should be updated after falls with or change in conditions with interventions. The administrator said the care plan coordinator from another facility is responsible for care plans at this time and has been covering this area since she has been here as the administrator. The administrator was not sure why the care plans are not up to date with falls and fall interventions. During an interview on 09/29/25 at 9:52 A.M., the care plan coordinator said he/she works approximately one and half days each week in the facility. The care plan coordinator said he/she believes the nursing staff should be documenting new falls and interventions on the resident's care plan, and that nursing staff has not made him/her aware of residents falls to include on the care plans. He/She said that new falls with new interventions should be included in the care plans.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265625	A. Building B. Wing	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire Senior Living New Florence	515 Picnic Street New Florence, MO 63363

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. Based on interview and record review, facility staff failed to ensure Certified Nurse Aid (CNA) G, nurse aid (NA) H and CNA I received a minimum of 12 hours of ongoing education annually. The facility census was 50.1. Review of the Facility's Nurse Aide Regular In-Service Training policy, dated 01/20/24, showed the in-service training must be sufficient to ensure the continuing competence of the nurse aides but must be no less than 12 hours per year, include dementia training and resident abuse prevention training, and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.Review of the facility's Resident Matrix, dated 09/22/25, showed staff documented 16 residents who resided in the facility with diagnoses of dementia and/or Alzheimer's disease.Review of the facility's records, showed the staff did not provide documentation CNA G, NA H, and CNA I completed or were provided with dementia and/or Alzheimer training.During an interview on 09/24/2025 at 2:40 P.M., the Director of Nurse (DON) said the facility does not have the required 12-hour trainings set up or implemented for NA staff. He/She said the facility got new ownership in May and they have yet to implement the NA 12-hour trainings. He/She said the old ownership did not leave any documentation that education was being completed previous to the ownership change.During an interview on 09/25/25 at 1:15 P.M., the administrator said he/she expects NA's to receive 12 hours of continued education yearly. He/She was not aware that NA's were not getting the education. He/She said the DON is responsible for the continued education, but he/she is new, he/she is the new administrator, and the facility came in new ownership a few months ago.