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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                     | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>265696 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                     | (X3) DATE SURVEY COMPLETED<br><br>03/13/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Aspire Senior Living Platte City |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>220 O'Rourke Drive<br>Platte City, MO 64079 |  |

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

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| (X4) ID PREFIX TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)  |
| <p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>44395</p> <p>Based on interview and record review the facility failed to protect one resident (Resident #4) of 6 sampled residents, right to be free from verbal and physical abuse when Certified Medication Technician (CMT) A called the resident derogatory names based on his/her body type and abilities and roughly pushed the resident's wheelchair forward. The facility census was 66.</p> <p>Review of the facility policy titled, Abuse Prevention Program, dated 1/20/25 showed:</p> <ul style="list-style-type: none"> <li>-It is the policy of this facility to provide protections for the health, welfare and rights of each resident;</li> <li>-Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation or punishment resulting in physical harm, pain, or mental anguish. Instance of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish. It includes verbal abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology;</li> <li>-Verbal abuse is defined as the use of oral, written, or gestured communication or sounds that willfully includes disparaging and derogatory terms to residents their families, or within their hearing distance, regardless of their age, ability to comprehend or disability.</li> </ul> <p>Review of Resident #4 Significant Change Minimum Data Set (MDS: a federally mandated assessment tool completed by facility staff) dated 1/28/25 showed:</p> <ul style="list-style-type: none"> <li>-Brief Interview of Mental Status (BIMS) of 12, indicated minimal cognitive loss;</li> <li>-Verbal behaviors (such as yelling, cursing) towards others for one to three of 7 days;</li> <li>-Moderate assistance on staff for Activities of Daily Living (ADLs: tasks completed in a day to care for oneself);</li> <li>-Use of wheelchair for mobility;</li> <li>-Use of oxygen;</li> </ul> <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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>- Diagnoses included: Extreme Binge Eating Disorder (is a serious condition involving feeling like one is not able to stop eating, and often involves eating much larger than usual amounts of food.) obesity, and anxiety. Hypertension (high blood pressure), Congestive Heart Failure (CHF: the heart cannot pump blood effectively), Chronic Obstructive Pulmonary Disease (COPD: lung disease that causes air flow obstruction and difficulty breathing).</p> <p>Review of the resident's face sheet showed he/she had a diagnosis of oxygen dependence.</p> <p>Review of the resident's Comprehensive Care Plan 1/28/25 showed:</p> <p>-Need for assistance with ADL's;</p> <p>-Impaired cognitive function.</p> <p>During an interview on 3/13/25 at 10:30 A.M. Resident #4 said:</p> <p>-He/She was fine;</p> <p>-He/She was not afraid of anyone;</p> <p>-No one had been rude, hateful or disrespectful to him/her;</p> <p>-Staff are good to him/her.</p> <p>During an interview on 3/13/25 at 2:00 P.M. HK A said:</p> <p>-He/She was at the D hall housekeeping closet on 3/11/25 around 7:45 A.M. when he/she heard CMT A yell get your ass to the closet three to four times;</p> <p>-HK A walked into the hallway, saw Resident #4 was sitting at the dining room door in his/her wheelchair, then he/she pedaled himself/herself a few feet into the hallway;</p> <p>-CMT A got behind the resident's wheelchair, grabbed the handles, pushed aggressively and said I told you to get your fat ass going as he/she pushed the resident around a corner;</p> <p>-HK A left the hall to notify his/her supervisor.</p> <p>During an interview on 3/13/25 at 3:18 P.M. CMT A said:</p> <p>-On 3/11/25 he/she was passing medications at the dining room;</p> <p>-He/She had told Resident #4 to wheel himself/herself to the oxygen closet;</p> <p>-Resident #4 had pedaled himself/herself a few feet into the hall from the dining room, then would not move;</p> <p>-He/She let his/her frustration get the best of him/her and said get your fat ass rolling to Resident #4;</p> <p>(continued on next page)</p> |  |  |

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| <p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>-Resident #4 was almost always out of oxygen in his/her tank in the mornings;</p> <p>-When he/she got the wheelchair he/she gave the resident an energetic push forward;</p> <p>-He/She had Abuse and Neglect education less than a month ago;</p> <p>-He/She knew better, yelling and cursing at the resident was another example of his/her temper getting away from him/her.</p> <p>Review of the facility investigation dated 3/11/25 showed:</p> <p>-8:00 A.M. an allegation of verbal abuse by CMT A to Resident #4 was reported to the Administrator by Housekeeping Aide (HK) A;</p> <p>-8:10 A.M. the resident's physician was notified of the alleged abuse;</p> <p>-8:12 A.M. the resident representative was notified of the alleged abuse;</p> <p>-8:15 A.M. interview with the reporter showed he/she had heard CMT A yell a derogatory term to Resident #4, while pushing the resident's wheelchair roughly;</p> <p>-8:20 A.M. interview with Resident #4 showed he/she was not aware of any derogatory term being used;</p> <p>-8:55 A.M. interview with CMT A showed, he/she was suspended and escorted out of the facility.</p> <p>During an interview on 3/13/25 at 4:10 P.M. the Administrator said:</p> <p>-CMT A's employment had been terminated;</p> <p>-The comments made by CMT A were abuse and unacceptable;</p> <p>-Immediate education was provided for staff;</p> <p>-She would not expect staff to curse or yell at residents.</p> <p>MO250870</p> |