STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265696	A. Building B. Wing	04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire Senior Living Platte City	220 O'Rourke Drive 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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on interview and record review the facility failed to ensure there was a safe and effective medication system in place when ordering and medication administration to ensure no significant medication errors, when one resident, Resident #1, received 28 doses of Torpenz 10mg tablet, a medication used to treat breast cancer, that was not ordered by the physician. This effected one of three sampled residents. The facility census was 66. On 04/16/26, the Administrator was notified of the past noncompliance which began on 03/18/26. On 04/16/26, the facility administrator was notified of the incident, an investigation immediately began and corrective actions were implemented to include education provided to licensed staff on 04/16/26 and 04/17/26. The education included inputting orders in the medical record. Check and verify the order is correct. A new system was put in place in which the Director of Nursing (DON) reviews new medication orders prior to the licensed staff forwarding the orders on to the pharmacy. The noncompliance was corrected on 04/17/26. Review of the facility policy titled, Receiving and Recording Medication Orders, dated 01/30/24 showed when recording orders for routine medications, specify the type, route, dosage, frequency and strength of the medication. Telephone orders may be accepted and must include name and strength of the drug, specific duration, corresponding diagnosis.Review of the facility, undated, policy titled, Resident Rights, showed the resident had the right to be fully informed, in advance, about the care and treatment that may affect the resident's wellbeing. Review of Resident #1's Quarterly Minimum Data Set (a federally mandated assessment tool completed by facility staff) dated 01/29/26 showed:-No cognitive impairment; -Diagnoses of: Heart failure, edema (swelling) and a history of heart attack;-No diagnosis of cancer. Review of the resident's March 2026 physician orders showed:-Torsemide Oral Tablet 20 milligram (MG) (Torsemide) Give 1 tablet by mouth one time a day for fluid retention, ordered 02/24/26; -Torpenz Oral Tablet 10 MG (Everolimus) Give 1 tablet by mouth one time a day for edema, ordered 03/18/26.Review of the resident's nurse progress Notes dated 03/18/26 showed Registered Nurse (RN) A documented New order received from Nurse Practitioner A, to decrease Torsemide to 10mg every day due to dry mouth. No note for the Torpenz medication. Review of the resident's March and April medication administration records (MAR) showed Torpenz 10mg tablet was administered daily from March 19, 2026 to March 31, 2026 and April 1, 2026 to April 15, 2026 for a total of 28 doses. Review of the resident's nurse progress notes dated 03/20/2026 to 04/15/26 showed he/she had multiple complaints of dry mouth, asking if any medications are dangerous, complaints of wanting the heat off and on multiple times due to feeling hot then cold, feeling of not being able to swallow, and difficulty swallowing due to dry mouth. Review of the Pharmacy Medication Error Report completed by Registered Pharmacist (RPh) A dated 04/16/26 showed on 04/15/26 a medication backorder form was requested by a data tech. The RPh reviewed the resident's full diagnosis to find an appropriate alternative. When no diagnosis of cancer was found, the RPh spoke with the facility with instructions to stop the medication and confirm the order for the medication. The nurse called the doctor and confirmed the medication should have been a dose change for Torsemide to 10 MG daily from 20 MG daily and the order had been entered incorrectly by the facility. Review of Inservice Education Record dated 04/16/26 to 04/17/26 showed: education was provided by the Director of Nursing. Topics included: putting orders in the medical record system, (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reading back and rechecking the order, ensure name, dose, frequency and route are correct.During an interview on 04/29/26 at 12:49 P.M. RN A said:-When he/she typed TOR into the electronic medical medication ordering system, Torpenz and Torsemide were side by side;-He/She thought he/she had picked the correct medication; -He/She did not read the order back before saving it in the electronic record;-New orders go to the pharmacy through the computer; -The resident often had complaints of dry mouth. -He/She had education on carefully entering orders, re-reading the order prior to saving it, and a new procedure for all orders to be sent to the DON for review and approval prior to being sent to the pharmacy; -He/She was involved in the Root Cause Analysis committee to determine what caused the medication error. During an interview on 04/29/26 at 12:52 P.M. the resident's Primary Care Physician (PCP) said:-The facility notified him of the error on 4/15/26 and the resident was sent to the hospital for evaluation and returned to the facility; -The resident was sent back to the hospital a week later, for an acute medical condition, not due to receiving Torpenz;-The pharmacy should have checked the order before filling it; -The resident complains all the time of anything and everything and was waxing and waning (a recurring, cyclical pattern where symptoms, emotions, or behaviors increase (wax) and decrease (wane) in intensity over time) in regards to behaviors;-There was no negative outcome to the resident from receiving the Torpenz.During an interview on 04/29/26 at 10:37 A.M. the Administrator said:-The medication error was caused because of a transcription error; -The medications Torpenz and Torsemide were next to each other in the electronic medical system, the nurse clicked the wrong medication; -The Torpenz was ordered for edema, which was not an approved use, and the pharmacy did not catch the error either; -A Root Cause Analysis was completed and determined it was user error; -Education was done with all nurses for transcription of orders, re-check the order before saving it, orders must be reviewed and approved by the Director of Nursing prior to being sent to the Pharmacy. During an interview on 04/29/26 at 2:00 P.M. the Assistant Director of Nursing said:-He/She recieved education on April 16th or 17th to read and re-read orders,then send the physician's order to the DON or management nurse on call for approval;-Once the order is approved the DON then checks to send the order to the pharmacy to be filled.During an interview on 04/29/26 at 2:15 P.M. RN B said:-He/She had only worked in the facility 3 days; -He/She recieved education to double check an order to ensure it was correct, notify the DON of the order, then the DON would approve the order and send it to Pharmacy; -If there were questions about an order he/she would clarify it with the physician and correct it in the computer before it would be ordered from the pharmacy. Intake 2988991