STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265821	A. Building B. Wing	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire Senior Living Excelsior Springs	1003 Meadowlark Lane Excelsior Springs, MO 64024

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility failed to prepare and serve food in accordance with professional standards for food service safety when facility staff failed to properly store and monitor food items for expiration dates, dispose of dented cans in a timely manner, and failed to maintain a three-day emergency food supply. This affected all residents in the facility. The facility census was 78.Request for facility Food Department Policies on food storage not provided;Observation in the Dry Storeroom on 1/5/25 at 9:00 A.M., showed:- Emergency Food Stock had only 12 cans of food and three bags of pasta for emergencies. - Two #10 sized cans of peans on the ground underneath the can storage rack. - Three rows of six #10 sized cans (18 total) in the can storage rack are dented and marked Do Not Use. - Three dented #10 sized cans on the ground labeled Do Not Use. Two are being used as door stops and one is just lying under a storage rack. One can is rusted and bulging on the side. - Large Plastic facility 5-gallon bin holding breadcrumbs dated 7/16/25 with no use by date.- Large Plastic facility 5-gallon bin holding gram cracker crumbs dated 10/18/25 with no use by date.- Large Plastic facility 5-gallon bin holding flour dated 10/14/25 with no use by date.- Large Plastic facility 5-gallon bin holding sugar dated 12/30/25 with no use by date.During an interview on 1/5/25 at 9:13 A.M., the Dietary Manager (DM) said:- There is not enough food in the emergency food supply to feed the residents for three days but she is working on restocking it through orders each week. - The dented cans have been here since the Thanksgiving and Christmas time frames. They are normally discarded with the food delivery driver once she feels the credit is large enough to make an impact. The food delivery driver will take them back anytime and regardless of quantity turned in and will give the facility credit for the dented cans. The food delivery driver comes to the facility weekly. Observation in the walk-refrigerator on 1/5/25 at 9:25 A.M., showed ground beef defrosting with a received date of 12/30/25 but no date for when defrosting started or a use by date.Interview on 1/5/25 at 9:27 A.M., the DM said that the hamburger was put in the refrigerator sometime during the weekend on 1/3/25 or 1/4/25. Observation in the Kitchen on 1/7/26 at 9:45 A.M., showed:- Dry storeroom had clear liquid shortening 5-gallon container, sitting on the ground;During an interview on 1/8/25 at 9:15 A.M., the DM said:- The budget is the main constraint on getting the three-day emergency food supply established quickly;- Food items should never be stored on the ground;- Bulk items such as sugar and flour are good for six months when they are not in their original storage packaging but should have a use by date;- There should be dating on food that is being defrosted as to when it started defrosting and when it should be used by;During an interview on 1/13/25 at 9:30 A.M., the Registered Dietician (RD) said:- Items that have been opened should be resealed and dated with a use by date and when they were originally opened;- Food items should not be stored on the ground;- Defrosted meat should have a date showing when it is to be used or at least when defrosting has started;- Dented cans should not be in the kitchen for four to six weeks, they should be turned in for credit at the next available opportunity;

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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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to inform residents and/or their responsible parties, in advance, of the risks and benefits of proposed care, when the facility failed to obtain written consent before beginning psychotropic medications (medications that affect the mind, emotions, and behavior) for three Residents (Resident #9, Resident #44, and Resident #68) of the 18 sampled residents. The facility census was 78. Review of the facility's Protecting, Promoting and Ensuring Resident Rights-Facility Responsibility policy, dated 1/30/25, showed every Resident has the right to be fully informed, in advance, about the care and treatment and of any changes in the care or treatment that may affect the resident's well-being. 1. Review of Resident #44's Quarterly Minimum Data Set (MDS) a federally mandated assessment tool completed by facility staff, dated 11/21/25, showed: - Cognition was intact - The resident took antianxiety medications on a regular basis; - The resident took antipsychotic medications on a regular basis; - The resident had diagnosis of anxiety and depression. Review of the resident's care plan, revised 11/21/25, showed: - The resident wishes to be included in his/her treatment plan; - The resident had an activities of daily living self-care deficit; - The resident used psychotropic medications for dementia with psychosis. Review of the resident's Physician's Order Sheet, dated 1/8/26, showed: - The resident began taking diazepam 2 milligrams (mg) by mouth at bedtime, an anti-anxiety medication, on 6/1/25; - The resident began taking quetiapine fumarate 12.5mg by mouth at bedtime, an antipsychotic medication, on 1/2/26; Review of the resident's electronic medical record showed there were no consents signed by the resident or the resident's representative before or after beginning these medications. 2. Review of Resident #68's Quarterly MDS, dated [DATE], showed: - The resident was not cognitively intact; - The resident was taking antianxiety, antipsychotic, and antidepressant medication on a regular basis; (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- The resident had diagnosis of anxiety, depression, and psychotic disorder. Review of the resident's care plan, revised 11/6/25, showed: - The resident had an activities of daily living self-care deficit related to confusion and limited range of motion; - The resident used psychotropic medication related to psychosis. Review of the resident's electronic medical record showed there were no consents signed by the resident or the resident's representative before or after beginning these medications. During an Interview on 01/05/2026 at 3:11 P.M. the resident's Durable Power of Attorney said the facility did not have him/her sign any paperwork regarding new medications, medication side effects, or medication changes. During an Interview on 01/08/2026 at 11:15 A.M. Registered Nurse (RN) A said: - He/she had not obtained written consent from the resident or their representative before beginning psychotropic medications; - He/she was not sure who is responsible for obtaining written consent before starting psychotropic medications. 3. Review of Resident #9's Minimum Data Set (MDS) dated [DATE], showed:- Cognition was not intact;- The resident took anti-anxiety and anti-depressant medication;- Diagnosis of depression, anxiety, and Post Traumatic Stress Disorder (PTSD, mental health condition triggered by experiencing or witnessing a traumatic event). Review of the resident's care plan, revised on 12/22/25, showed:- The resident had pain related to disability and depression and relied on nursing staff to anticipate and meet needs;- The resident had a psychosocial well-being problem and relied on staff to encourage him/her to socialize and participate in activities. Review of the resident's Physician's Order Sheet, dated 1/6/26, showed:- The resident began taking the anti-depressant medication Trazodone 100 milligrams (mg) daily on 10/6/25; - The resident began taking the anti-depressant medication Venlafaxine 150 mg daily on 10/9/25;- The resident began taking the anti-depressant medication Bupropion 150 mg one time a day on 10/11/25. Review of the resident's electronic record showed no consents had been signed by the resident and/or resident's representatives before or after medication administration. During an interview on 1/8/2026 at 8:12 A.M., the Assistant Director of Nursing (ADON) said:- Residents and their representatives should know potential side effects and reasons for taking psychotropic medications before taking them;- There should be signed psychotropic consents. We do get signed consent for psychiatric doctor to treat but have learned that is not sufficient. During an interview on 1/8/2026 at 10:30 A.M., the Director of Nursing (DON) said:- Residents and their representatives should know potential side effects and reasons for taking psychotropic medications before taking them;- He had never had the expectation to require psychotropic consents, that was a new one for him as he was newer to long term care. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/8/2026 at 12:17 P.M., the Administrator said:- Residents and their representatives should know the potential side effects and reasons for taking psychotropic medications before taking them;- There should be signed psychotropic consents.

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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide personal funds and a final accounting within thirty days upon discharge for five residents (Resident #85, #86, #87, #88 and #89) and failed to notify by letter one resident (Resident #7) when they were within $200.00 of the Supplemental Security Income (SSI) resources limit. This affected six of 18 residents sampled. Facility census was 78. Review of facility policy Facility Resident Trust Fund, undated, showed:- The individuals trust account should be kept below the balance of $5700.00 as a best practice rule, however, the current limit for Medicaid recipients is $5909.25. Any individual Resident Trust Account that is nearing (within $200 dollars) the state specified maximum balance will require the following action: notification to resident or responsible party via letter, discussion on items resident might need for comfort.- Refund for discharged resident: Must be completed within 5 business days of the resident discharge.- Refund for expired resident: Facilities must submit the Personal Funds Account Balance Report (TPL Form) to MO HealthNet for expired resident that were MO Healthet participants.- Certified facilities must submit the TPL Form within 30 days of expiration.- DSS will respond to the TPL with determination for the remaining fund and instructions should be executed within 60 days of the response.- Funeral expenses are the only funds to be surrendered after expiration. 1. Resident #7's Quarterly Minimum Date Set (MDS-a federally required assessment tool completed by facility staff), dated [DATE], showed: - Moderate cognitive impairment;- Diagnoses: anemia, diabetes, hip fracture, seizure disorder, bipolar disorder, psychotic disorder and anxiety disorder.Review of the facility's Accounts Receivable Aging Report, dated [DATE], and Current Resident Trust Fund Balance Sheet, dated [DATE], showed Resident #7 had a balance of $8,072.15 in the Resident Trust Account that was owed to the resident.During an interview on [DATE] at 8:55 A.M., the Business Office (BO) said:- She had a conversation with the resident about spending down his/her balance a month or so ago. She did not know that a letter was required to inform the resident of the need to spend down the balance when it got within $200 of the State required limit which the resident was currently above.2. Review of the facility's Accounts Receivable Aging Report, dated [DATE], and Current Resident Trust Fund Balance Sheet, dated [DATE], showed:- Resident #85 discharged on [DATE] and had a balance of $3.51 in the Resident Trust Account;- Resident #86 expired on [DATE] and had a balance of $268.27 in the Resident Trust Account;- Resident #87 discharged on [DATE] and had a balance of $10.00 in the Resident Trust Account;- Resident #88 discharged on [DATE] and had a balance of $57.31 in the Resident Trust Account;- Resident #89 was not listed on the accounts receivable aging report and had a balance of $27.38 in the Resident Trust Account. During an interview on [DATE] at 12:40 P.M., the BO said:- Residents #85, #86, #88, and #89 should have been refunded or their money sent back to Medicaid. These were oversights which she is working on to fix. - Resident #87 was issued a $10.00 check but it was returned undelivered back to the facility.During an interview on [DATE] at 2:40 P.M., the Administrator said resident accounts should be reconciled and refunded as necessary within 5 days of discharge but no later than 30 days.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to provide privacy for two Residents (Resident #2 and #39) of 18 sampled residents during cares when staff failed to close the privacy curtain during peri-care for Resident #39 and failed to close the window blinds when performing a dressing change to Resident #2's buttock wound. The census was 78. Review of the facilities Perineal Care policy, dated April 2025, showed:- Staff were to provide privacy by pulling curtain or closing room door if a private room. Review of the facilities Resident Rights policy, dated April 2025, showed:- The facility will treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his/her quality of life and recognizes each resident's individuality;- The resident has the right to personal privacy;- When providing resident care, always provide privacy by knocking and announcing yourself, pulling the curtain around the bed, pulling the drapes to windows, closing the door, and draping the resident's body appropriately. 1. Review of Resident #39's Minimum Data Set (MDS) a federally mandated assessment tool completed by facility staff, dated 11/5/25, showed:- Cognition was not intact;- The resident was dependent on staff for showers, transfers, and dressing;- Diagnosis of Alzheimer's disease, respiratory failure, and heart failure. Review of the resident's care plan, revised on 1/5/26, showed:- The resident required anti-anxiety medication;- The resident had a self-care deficit and relied on nursing staff to anticipate and meet needs;- The resident was totally dependent on staff for cares. Observation on 1/5/2026 at 3:32 P.M., showed:- Certified Nursing Assistant (CNA) B and CNA C entered the resident's room to perform peri-care and closed the resident's door;- The curtain between the resident and the resident's roommate, who was lying in his/her bed and able to observe the procedure, remained open;- The resident was exposed and peri-care performed in full view of the roommate. During an interview on 1/5/26 at 3:32 P.M CNA B said he/she would normally provide proper privacy between the resident and the roommate but did not. During an interview on 1/6/2026 at 3:15 P.M., CNA D said staff should pull the curtain between residents to provide privacy and preserve their dignity. During an interview on 1/8/2026 at 8:12 A.M., the Assistant Director of Nursing (ADON) said:- Privacy should be provided when performing peri care on the residents, including pulling the curtains;- The facility provides training on privacy and proper cleaning with the aides. During an interview on 1/8/2026 at 10:30 A.M., the Director of Nursing said privacy should be provided for the residents when the staff are performing peri-care. During an interview on 1/8/2026 at 12:17 P.M., the Administrator said:-Nursing staff should provide privacy when performing peri-care on the residents;-Privacy provided would also include the curtains are pulled and window blinds closed. 2. Review of Resident #2's Quarterly Minimum Data Set (MDS), dated [DATE], showed: (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The resident was cognitively intact; The resident was dependent on staff for toileting, bathing, and dressing; The resident had diagnosis of muscle weakness, stage three pressure ulcer of right buttock, and neuromuscular dysfunction of the bladder. Review of the resident's care plan, revised 11/26/25, showed: The resident had a colostomy; The resident was on hospice (care that focuses on comfort rather than curing the disease); The resident had an above the knee amputation to the right leg. Observation on 01/08/2026 at 10:16 A.M. showed: The Assistant Director of Nursing (ADON) and Licensed Practical Nurse (LPN) B provided wound care to the resident; The resident's perineal area and buttock were exposed to provide wound care; While the resident was exposed the blinds to the window next to the resident's bed were opened to the parking lot and a car drove into the parking lot and parked while care was being provided. During an Interview on 01/08/2026 at 11:19 A.M. Resident #2 said He/she just wanted staff to do what they needed to do, in regard to providing privacy during care. During an Interview on 01/08/2026 at 10:55 A.M. the ADON said blinds in the resident's room should be closed when providing care to the resident to maintain privacy. During an Interview on 01/08/2026 at 11:15 A.M. Registered Nurse (RN) A said privacy should be provided to resident's when providing care when the resident would be exposed. During an Interview on 01/08/2026 at 11:55 A.M. Certified Medication Technician (CMT) B said blinds in resident's rooms should be closed when providing care when the resident would be exposed. During an Interview on 01/08/2026 at 1:01 P.M. Certified Nursing Assistant (CNA) E said blinds should be closed, with the door shut and curtains pulled when providing care to a resident who would be exposed. During an Interview on 01/08/2026 at 12:55 P.M. The Director of Nursing (DON) said blinds should be closed and curtains should be pulled when performing any care where the resident would be exposed.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities Based on interview and record review, the facility failed to ensure an assessment of the Level I preadmission screening resident review (PASARR) assessment (used to identify individuals with mental illness or intellectual/developmental disabilities completed before admission to the nursing facility) was completed before admission for two Residents (Resident #68 and Resident #80). The affected two of 18 sampled residents. The facility census was 78. Review of the facility's Preadmission Screening for Individuals with a Mental Disorder/Intellectual Disability PASARR policy, dated 1/30/24, showed:- Ensure each resident in a nursing facility is screened for a mental disorder or intellectual disability prior to admission; - The initial screening is referred to as Level I identification of individuals with mental disorder or intellectual disability and is completed prior to admission to this facility;- PASARR is a federal requirement to help ensure that individuals who have a mental disorder or intellectual disabilities are not inappropriately placed in nursing homes for long term care. 1.Review of Resident #68's Quarterly Minimum Data Set (MDS) a federally required assessment tool completed by facility staff, dated 11/6/25, showed:- Cognition was not intact;- Was dependent on staff for completing activities of daily living;- Diagnoses of anxiety, depression, and psychotic disorder. Review of the resident's care plan, revised 11/6/25, showed:-He/She had the potential to be physically aggressive related to dementia;-He/She used psychotropic medications (medications that affect the mind, emotions, and behavior) related to psychosis;-He/She used anti-anxiety medication related to an anxiety disorder. Review of the resident's medical record showed that no documentation of a Level I PASARR had been completed. During an Interview on 01/08/2026 at 1:31 P.M. the Social Services Director (SSD) said:- The facility does not have documentation that a Level I PASARR had been completed; but they should have had one completed prior to admission;- The resident had admitted from a different facility and that facility did not provide documentation of a Level I PASARR;- She was not sure if the resident had a Level I PASARR completed. During an Interview on 01/08/2026 at 12:18 P.M. the Administrator said a Level I PASARR for each resident should be in the electronic medical record. When a resident is admitted from another facility, this facility will attempt to obtain the Level I PASARR from the other facility, but they do not always send it. During an Interview on 01/08/2026 at 12:55 P.M. the Director of Nursing (DON) said a Level I PASARR should be completed before a resident is admitted to the facility; and should have been done for this resident. He was not sure what the policy is on obtaining a PASARR for a resident if they were being admitted from another facility.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based interview and record review the facility failed to provided care and treatment in of accordance with professional standards of practice when facility staff failed to follow physician's orders for three of 18 sampled residents (Resident #5, #24 and #68), when staff did not provide Mighty Shakes (a nutritional supplement used in individuals needing supplemental nutrition) and failed to notify the physician the shakes had not been given to Residents #5, #51 and #68 as ordered. The facility census was 78.The facility did not provide the requested policy regarding professional standards. 1.Review of Resident #5's Quarterly Minimum Data Set (MDS), a federally mandated instrument completed by facility staff dated 11/20/25 showed:-No cognitive impairment;-Partial assistance from staff with bed mobility and toileting; -Incontinent of bowel and bladder; -Diagnoses included dementia, low blood pressure and anxiety. Review of the resident's care plan dated 11/22/25 showed:-The resident had a potential nutritional problem related to dementia;-The resident was ordered a Mighty Shake in the morning to help promote weight gain. Review of the resident's Physician's Order Sheet (POS) dated January 2026, showed the order start date was 11/25/25, for a Mighty Shake three times a day. Review of the resident's Medication Administration Record (MAR) dated December 2025, showed no mighty shakes were given on the following days:-12/8/25 at 10:39 A.M.;-12/8/25 at 3:08 P.M.; -12/9/25 at 9:43 A.M.; -12/16/25 at 10:13 A.M.; -12/21/25 at 12:40 P.M.; -12/22/25 at 10:58 A.M.;-12/22/25 at 2:36 P.M.;-12/22/25 at 8:12 P.M.;-12/23/25 at 8:34 A.M.;-12/30/25 at 8:43 A.M. Review of the resident's MAR dated January 2026, showed no mighty shakes were given on the following days:-1/5/26 at 9:24 A.M.;-1/5/26 at 8:09 P.M.;-1/6/26 at 8:09 A.M. Review of the residents nurse's notes showed:-12/8/25 at 10:39 A.M., Mighty shake, out of supplement at this time;-12/8/25 at 3:08 P.M., Mighty shake, out of supplement at this time;-12/9/25 at 9:43 A.M., Mighty shake, out of supplement at this time;-12/16/25 at 10:13 A.M., Mighty shake, out of supplement at this time;-12/21/25 at 12:40 P.M., Mighty shake, out of supplement at this time;-12/22/25 at 10:58 A.M., Mighty shake, out of supplement at this time;-12/22/25 at 2:36 P.M., Mighty shake, out of supplement at this time;-12/22/25 at 8:12 P.M., Mighty shake, out of supplement at this time;-12/23/25 at 8:34 A.M., Mighty shake, out of supplement at this time;-12/30/25 at 8:43 A.M., Mighty shake, out of supplement at this time;-1/5/26 at 9:24 A.M., Mighty shake, out of supplement at this time;-1/5/26 at 8:09 P.M., Mighty shake, out of supplement at this time;-1/6/26 at 8:09 A.M., Mighty Shake, out of supplement at this time;-No documentation in the clinical record showed the Physician or Registered Dietitian (RD) had been notified. 2. Review of Resident #4's Quarterly MDS dated [DATE] showed:-Severe cognitive impairment;-Dependent on staff for toileting and bed mobility;-Diagnoses included heart failure, high blood pressure and anemia. Review of the resident's care plan dated 12/23/25 showed:-The care plan did not address the resident's use of health shakes. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's POS dated January 2026 showed the order start date was 8/12/15, for Mighty Shake three times a day. Review of the resident's MAR dated December 2026, showed no there was no Mighty Shakes were given on the following days:-12/8/25 at 8:00 A.M.;-12/8/25 at 12:00 P.M.; -12/9/25 at 8:00 A.M.; -12/16/25 at 8:00 A.M.; -12/22/25 at 8:00 A.M.;-12/22/25 at 12:00 P.M.;-12/22/25 at 8:12 P.M.;-12/23/25 at 8:00 A.M.-12/30/25 at 8:43 A.M. Review of the resident's MAR dated January 2026, showed no mighty shakes were given on the following days:-1/5/26 at 8:00 A.M.;-1/5/26 at 12:00 P.M.;-1/6/26 at 8:00 A.M. Review of the residents nurse's notes showed:-12/8/25 at 10:40 A.M., Mighty shake, out of supplement at this time;-12/8/25 at 3:18 P.M., Mighty shake, out of supplement at this time;-12/9/25 at 9:42 A.M., Mighty shake, out of supplement at this time;-12/16/25 at 10:15 A.M., Mighty shake, out of supplement at this time;-12/21/25 at 12:50 P.M., Mighty shake, out of supplement at this time;-12/22/25 at 10:43 A.M., Mighty shake, out of supplement at this time;-12/22/25 at 2:38 P.M., Mighty shake, out of supplement at this time;-12/22/25 at 8:19 P.M., Mighty shake, out of supplement at this time;-12/23/25 at 8:40 A.M., Mighty shake, out of supplement at this time;-12/30/25 at 8:31 A.M., Mighty shake, out of supplement at this time;-1/5/26 at 9:43 A.M., Mighty shake, out of supplement at this time;-1/5/26 at 8:05 P.M., Mighty shake, out of supplement at this time;-1/6/26 at 8:10 A.M., Mighty Shake, out of supplement at this time;-No documentation showed the physician or RD had been notified. During an interview on 01/07/26 at 10:53 A.M., Certified Nurse Aid (CNA) A said:-The CNAs did not give out the health shakes;-The nurses and Certified Medication Technician (CMT)s gave the health shakes. During an interview on 01/07/26 at 11:03 A.M., Licensed Practical Nurse (LPN) A said:-Resident's who get a Mighty Shake have a physician's order for it;-The CMT's pass the Mighty Shakes out most of the time;-Physician's orders should be followed;-If a physician's order's cannot be followed the physician should be notified;-He/She did not know if the physician had been notified when the facility ran out of the Mighty Shakes and they were not given. During an interview on 01/07/26 at 11:18 A.M., CMT A said:-Sometimes the facility is out of Mighty Shakes;-When shakes supply is low he/she told the dietary manager;-He/She did not notify the nurse or the physician because the dietary department ordered the shakes;-He/She did not notify the nurse when the resident did not get the mighty shake;-The Mighty Shake is a physician's order and should be followed. During an interview on 01/08/26 at 10:00 A.M. the Dietary Manager (DM) said:-The facility can hold 5-6 cases of shake mix in the freezer indefinitely;-They take one case at a time out and defrost it in the refrigerator;-The CNAs will occasionally come up and tell her they are going through a lot of the shakes. During an interview on 01/08/2026 at 1:21 P.M., the Director of Nursing (DON) said: -If a physician's order is not being followed the physician should be notified;-The shake is ordered by the physician and the physician should be notified if it had not been given. During an interview on 1/8/26 at 1:43 P.M., the Administrator said:-She expected the nurse's to be (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	notified by the CMT's when the shakes were not given;-She expected physician and the RD to be notified by the nurse when the shakes were not given;-She expected physician's orders to be followed. During an interview on 1/12/26 at 10:11 A.M., the RD said:-She issued a blanket order for nutritional supplements;-She expected staff should find a suitable substitute if they run out of the Mighty Shakes;-She had not been notified the facility had ran out of Mighty Shakes;-She had not been notified the residents had not received the shakes;-She would expect to be notified if the faculty was out of shakes and the residents had not received them. 3. Review of Resident #68's Quarterly Minimum Data Set (MDS) a federally required assessment tool completed by home staff, dated 11/6/25, showed: - The resident was dependent on staff for activities of daily living; - The resident was not cognitively intact; - The resident had diagnosis of Parkinson's Disease, muscle weakness, and Alzheimer's Disease. Review of the resident's care plan, revised 11/6/25, showed: - The resident had limited physical mobility; - The resident had potential for nutritional issues related to dementia; - The resident was on hospice (care that focuses on comfort rather than curing the disease) care. Review of the resident's Physician Order Sheet, dated 1/6/26, showed: The resident had an order for Mighty Shake three times a day for weight loss with meals that began on 12/16/25. Review of the resident's Medication Administration Record for the month of December 2025, showed: - No Mighty Shake as ordered at noon on 12/19/25 provided due to the shakes being frozen; - No Mighty Shake as ordered at 5:00 P.M. on 12/21/25 due to the shakes not being available; - No Mighty Shake as ordered at 8:00 A.M. and noon on 12/22/25 due to the shakes not being available; - No Mighty Shake as ordered at 8:00 A.M. on 12/23/25 due to no shakes available. Review of the resident's Medication Administration Record for the month of January 2026, showed: - No Mighty Shake as ordered at 8:00 A.M. and noon on 1/5/26 due to the shakes not being available; - No Mighty Shake as ordered at 8:00 A.M. on 1/6/25 due to the shakes not being available. During an Interview on 01/06/2026 at 3:20 P.M. Certified Medication Technician (CMT) C said: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Dietary staff was responsible for ordering Mighty Shakes; - The facility uses a case a day of the Mighty Shakes and will usually start to run short on mighty shakes on Mondays before the new shipment comes in on Tuesdays; - The home had not ran out of Mighty Shakes for more than a day at a time. During an Interview on 01/08/2026 at 11:55 A.M. CMT B said the facility runs out of Mighty Shakes. During an Interview on 01/08/2026 at 12:55 P.M. the Director of Nursing (DON) said If Mighty Shakes are not available the CMT should notify the nurse, the administrator, and the kitchen so more can be ordered.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews the facility failed to ensure dependent residents who were unable to carry out activities of daily living (ADLs) received the necessary services to maintain good personal hygiene when facility staff did not provide proper incontinence care for two of 18 sampled residents (Resident #2 and #39). The facility census was 78. Review of the facilities Perineal Care policy, dated April 2025, showed:- It is the practice of this a facility to provide perineal care to all incontinent residents during routine bath and as needed in order to promote cleanliness and comfort, prevent infection to the extent possible, and to prevent and assess for skin breakdown;- Staff were to provide privacy by pulling curtain or closing room door if a private room;- Cleanse buttocks and anus, front to back; vagina to anus in females and scrotum to anus in males, using a separate washcloth or wipes;- Separate the resident's genital folds with one hand and cleanse perineum with the other hand, repeat on opposite side using new disposable wipe with each stroke;- Clean urethral meatus or vaginal orifice using new disposable wipe with each stroke;- Clean and dry the anal area, starting at the posterior genital area and wiping from front to back. 1. Review of Resident #39's Minimum Data Set (MDS) a federally mandated assessment tool completed by facility staff, dated 11/5/25, showed:- Cognition was not intact;- The resident was dependent on staff for showers, transfers, and dressing;- Diagnoses of Alzheimer's disease, respiratory failure, and heart failure. Review of the resident's care plan, revised on 1/5/26, showed:- Use of anti-anxiety medication;- Required total assist of all activities of daily living (ADL); Observation on 1/5/2026 at 3:32 P.M., showed:- Certified Nursing Assistant (CNA) B and CNA C entered the resident's room to perform peri-care;- Both CNA's washed hands and applied gloves;- CNA B wiped down the resident's inner thigh and repeated with a new cleansing wipe down the other side of the inner thigh;- CNA B then took one cleansing wipe and twisted it into the front of genital opening but never spread the surrounding skin folds;- CNA B wiped down leg then up to anus but never spread folds or verified cleanliness; During an interview on 1/5/26 at 3:32 P.M. CNA B said he/she would normally wipe all areas that had been exposed to urine or feces and not just the middle of the genital opening but should have. During an interview on 1/6/2026 at 3:15 P.M., CNA D said:- Nursing should pull the curtain between residents to provide privacy and for their dignity;- Nursing should spread skin folds and clean everywhere that urine and stool could touch. On 1/7/2026 at 4:04 P.M. an anonymous employee interview said CNA B did not provide good peri-care to two residents who required toileting and changing. During an interview on 1/8/2026 at 8:12 A.M., the Assistant Director of Nursing (ADON) said nursing staff are to clean all areas where urine or feces touched when performing peri-cares on residents; nursing staff are trained on proper cleaning with peri care. During an interview on 1/8/2026 at 10:30 A.M., the Director of Nursing (DON) said:- Clean all areas where urine or feces could touch the skin when performing peri-cares on residents;- Improper peri-care on residents causes skin breakdown and odors;- Privacy should be provided when (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	performing peri care. During an interview on 1/8/2026 at 12:17 P.M., the Administrator said nursing staff should clean all areas on a resident where urine or feces could have touched when performing peri- care and privacy should be provided. 2. Review of Resident #2's Quarterly Minimum Data Set (MDS), dated [DATE], showed: - The resident was cognitively intact; - The resident was dependent on staff for personal hygiene; - The resident had diagnosis of irritant contact dermatitis due to friction or contact with body fluids, urinary tract infection, and neuromuscular dysfunction of bladder. Review of the resident's care plan, revised 11/26/25, showed: - The resident had a activities of daily living self-care deficit; - The resident had recurrent urinary tact infections related to suprapubic catheter (a tube inserted directly into the bladder through a small opening in the lower abdomen). Observation on 01/08/2026 at 10:16 A.M. showed: - The Assistant Director of Nursing (ADON) provided perineal care to the resident after completing the resident's wound treatment; - The ADON cleaned the resident's perineal area by wiping once down the middle of the perineal area, folded the wipe and used the same wipe to wipe down the middle of the perineal area. During an Interview on 01/08/2026 at 10:55 A.M. the ADON said: -The cleansing wipe can be folded and used again when provided perineal care; - A cleansing wipe should not be folded and used again more than three times when providing perineal care. During an Interview on 01/08/2026 at 1:01 P.M. Certified Nursing Assistant (CNA) E said a cleansing wipe should only be used once when providing perineal care. During an Interview on 01/08/2026 at 12:18 P.M. The Administrator said a cleansing wipe should only be used once when providing perineal care. During an Interview on 01/08/2026 at 12:55 P.M. the Director of Nursing said a cleansing wipe should not be folded and reused when providing perineal care. Intake 2711323

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide proper respiratory care when staff failed to document the date when oxygen tubing was cleaned for four residents (Residents #2, #9, #29, and #39) and additionally failed to properly store oxygen accessories at the bedside for two residents (Resident #2 and #29). This affected four of 18 sampled residents. The facility census was 78.Review of the facility's Oxygen Administration policy, dated April 2006, showed:- There was no specific guidance on changing out prefilled disposable humidifiers by month or week;- Label humidifier with date and time opened. There was no guidance for when oxygen tubing should be changed;- Precaution - constant flow of oxygen can cause drying and thickening of normal secretions resulting in laryngeal ulceration;- There was no guidance on regular intervals to check and clean oxygen equipment, masks, tubing, or nasal cannulas;- There was no guidance on regular intervals to check liter flow contents of oxygen cylinder, fluid level in humidifier. 1. Review of Resident #9's Minimum Data Set (MDS) a federally mandated assessment tool completed by facility staff, dated 12/31/25, showed:- Cognition was not intact;- He/She was dependent on staff for showers and required setup assistance with all other Activities of Daily Living (ADL's);- Diagnoses included: respiratory failure, diabetes, and Post Traumatic Stress Disorder (PTSD, mental health condition triggered by experiencing or witnessing a traumatic event). Review of the resident's care plan, revised on 12/22/25, showed no staff direction related to oxygen use or care of equipment; Review of the Order Summary Report, dated 1/8/26, showed an order for staff to change oxygen tubing and humidifier every day shift on Sundays. Observation on 1/5/26 at 10:50 A.M., showed:- A humidifier bottle attached to the running concentrator dated 12/28;- An empty bag tied to the running concentrator dated 7/27;- Nebulizer tubing sat open on the nightstand dated 12/28;- The oxygen tubing, worn by the resident, had no date written on the attached tubing. Observation on 1/7/26 at 7:56 A.M., showed:- A humidifier bottle attached to the running concentrator dated 12/28;- A empty bag tied to the running concentrator dated 7/27;- Nebulizer tubing sat on the nightstand dated 12/28;- The oxygen tubing, being worn by the resident, with no date written on or attached to the tubing. Observation on 1/8/26 at 10:23 A.M., showed:- A humidifier bottle attached to the running concentrator dated 12/28;- An empty bag tied to the running concentrator dated 7/27;- Nebulizer tubing sat open on the nightstand dated 12/28;- The oxygen tubing, worn by the resident, with no date attached to the tubing. 2.Review of the resident's Minimum Data Set (MDS) a federally mandated assessment tool completed by facility staff, dated 11/24/25, showed:- Cognition was intact;- He/She required substantial assistance with showers, toileting, transfers and oxygen equipment;- Diagnoses included respiratory failure, diabetes, and heart failure. Review of Resident #29's care plan, revised on 11/13/25, showed:- He/She required oxygen therapy with oxygen ordered at two liters per minute via nasal cannula;- He/She relied on nursing staff to anticipate and meet all care needs. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's Physician Order Summary Report, dated 1/8/26, showed an order for staff to change oxygen tubing and humidifier every night shift on Wednesdays. During an interview and observation on 1/5/2026 at 10:08 A.M., the Resident said:- He/She required oxygen all the time due to his/her diagnoses;- He/She got breathing treatments;- His/Her nose got dry and he/she had a bloody nose most of the time;- He/she had oxygen tubing on and was attached to the running concentrator without a date;- The oxygen tubing storage bag was dated 1-1;- No humidifier bottle was attached to the concentrator;- Oxygen tubing attached to the portable oxygen tank on the resident's wheelchair was not dated. Observation on 1/6/2026 at 12:51 P.M., showed: - Oxygen supply storage bag was dated 1/1;- Oxygen tubing attached to the concentrator was undated;- No humidifier bottle was attached to the concentrator. Observation on 1/8/2026 at 10:23 A.M., showed the resident's oxygen tubing had been replaced and dated on 1/7/26, but no humidifier bottle was attached to the concentrator per the physician's order. 3. Review of Resident #39's Minimum Data Set (MDS), dated [DATE], showed:- Cognition was not intact;- The resident was dependent on staff for showers, transfers, and dressing;- Diagnoses included Alzheimer's disease, respiratory failure, and heart failure. Review of the resident's care plan, revised on 1/5/26, showed:- He/She required oxygen therapy with oxygen settings at two liters via nasal cannula;- He/She relied on nursing staff to anticipate and meet all care needs. Review of the resident's Physician Order Summary Report, dated 1/8/26, showed an order for staff to change oxygen tubing and humidifier every day shift on Sundays. Observation on 1/5/2026 at 2:34 P.M., showed:- He/She had oxygen applied via nasal cannula;- The humidifier bottle was empty, connected to the oxygen concentrator, and undated;- The oxygen tubing was connected to the oxygen concentrator and was undated;- The supply storage bag attached to the concentrator was not dated. Observation on 1/6/26 at 3:15 P.M., showed:- Oxygen humidifier bottle attached to the concentrator had been changed and dated 1/6/26- The tubing attached to the portable oxygen cannister was not dated. During an interview on 1/6/2026 at 3:15 P.M., Certified Nursing Assistant (CNA) D said:- Night shift staff change and date the oxygen tubing and humidifier bottles;- Day shift staff change the oxygen bottles on days if they were empty;- Staff date the oxygen tubing when changed. During an interview on 1/8/2026 at 8:12 A.M., the Assistant Director of Nursing (ADON) said: -The resident's oxygen tubing should be changed and dated when changed;-Staff change out tubing and equipment on Saturday or Wednesday on the evening shift;-The supplies storage bag is to be changed and dated on the same days;-The humidifier bottle is to be changed and dated; - A humidifier bottle is provided, if ordered by the provider and care planned for the resident to have one. During an interview on 1/8/2026 at 10:30 A.M., the Director of Nursing (DON) said: - Oxygen tubing is to be changed and dated when changed. Normally by the evening shift staff;- The oxygen supply storage bag is to be changed and dated;- The humidifier bottle is to be changed and dated and in place if ordered by the provider or care planned for the resident. During an interview on 1/8/2026 at 12:17 P.M., the Administrator said:- Oxygen tubing and oxygen supplies storage bags should be changed and dated when changed by the staff;- Normally the evening (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	shift staff change and date the respiratory equipment;- The humidifier bottle should be changed and dated when changed;- There should be a humidifier bottle attached to the concentrator if it was ordered by the provider or care planned for the resident. 4. Review of Resident #2's Quarterly Minimum Data Set (MDS) dated [DATE] showed: - He/She had trouble breathing at rest and with exertion and was prescribed Oxygen; - Diagnosis included chronic obstructive pulmonary disease (COPD) a progressive lung condition that blocks air flow, making it difficult to breathe. Review of the resident's care plan, revised 11/26/25, showed: -He/She required oxygen therapy as needed related to COPD; -He/She was on hospice (care that focuses on comfort rather than curing the disease). -He/She was dependent on nursing staff to meet oxygen equipment needs. Review of the resident's Physician Order Sheet, dated 1/8/26, showed: - An order for oxygen at one to three liters per nasal cannula as needed; - An order for oxygen tubing and humidifier to be changed every Sunday on night shift Observation on 01/05/2026 at 9:45 A.M. showed: - The nasal cannula tubing in use did not have a date indicating when the tubing was last changed; - No humidifier bottle attached to the resident's oxygen concentrator. During an Interview on 01/08/2026 at 11:09 A.M. the resident said he/she would like to have humidified oxygen since his/her nose does get dry while wearing oxygen and it bothers him/her. During an Interview on 01/08/2026 at 11:15 A.M. Registered Nurse (RN) A said: - Oxygen tubing was changed monthly; - Some resident's had orders for oxygen tubing to be changed on dayshift some had orders to be changed on nightshift; - Oxygen tubing should be dated when it was changed; - Residents who had an order for humidified oxygen should be provided with humidified oxygen. - Residents who wish to have humidified oxygen, staff can obtain a physician's order.

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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, record review, and interviews, the facility failed to ensure they assessed residents for risk of entrapment from bed rails prior to installation and when staff failed to ensure the bed's dimensions were appropriate for the resident's size and weight for three of 18 residents sampled (Residents #51, #4 and #24). The facility census was 78.Review of the facility's Bed Rails policy dated 1/30/2024 showed:-Ensure correct installation and maintenance of bed rails;-The facility will ensure correct installation and use maintenance of bed rails; -The facility will assess the resident's risk for entrapment from bed rails prior to installation and ensure the beds dimensions are appropriate for the residents size and weight;-The facility will follow the manufacturers recommendations and specifications for installing and maintaining bed rails; -The facility will inspect and regularly check the mattress and bed rails for areas of possible entrapment;-The facility must conduct routine preventive maintenance of bed rails and this should be evidenced in the residence record.1. Review of Resident #51's quarterly Minimum Data Set (MDS), a federally mandated instrument completed by facility staff dated 08/05/25 showed:-No cognitive impairment;-Dependent on staff for toileting and bed mobility;-Incontinent of bowel and bladder;-Two or more falls with injury since admission;-Diagnoses included Multiple Sclerosis (MS) a chronic autoimmune disease that can cause high cholesterol and depression.Review of the resident's care plan dated 01/04/26 showed:-Diagnosis of MS;-At risk for falls;-The resident had a non-injury fall on 09/23/25;-The resident had a fall with injury on 01/01/26; -Used bilateral cane rails for bed mobility and positioning.Review of the resident's Physician's Order Sheet (POS) dated January 2026 showed an order for bilateral cane rails for bed mobility and positioning.Review of the resident's nurse's notes showed:-12/31/25 5:30 P.M., the resident was observed on the floor by the staff. The resident's right arm was caught behind him/her with his/her back to the dresser; -12/31/25 at 6:56 P.M., staff assisted the resident up in bed. The resident said he/she reached off the side of the bed to get something off the floor and his/her shoulder got caught in the bed rail.Observation on 1/6/26 at 3:11 P.M., showed:-The resident lying in bed and yelling for the staff;-Both bilateral cane rails in the up position at the head of the bed.Observation and interview on 1/7/26 at 10:48 A.M., showed:-The resident lying in bed;-Both bilateral cane rails in the up position at the head of the bed;-The resident said the rails helped him/her get out of bed.2. Review of Resident #4's quarterly MDS dated [DATE] showed:-Severe cognitive impairment;-Dependent on staff for toileting and bed mobility;-One fall with injury since admission;-Diagnoses included heart failure, high blood pressure and anemia.Review of the resident's bed rail assessment dated [DATE] showed:-History of falls;-Bilateral assist bars used;-No height or weight of the resident was found on the assessment;-No documentation to confirm the bed rails installed were appropriate to the size and weight of the resident.Review of the resident's care plan dated 12/23/25 showed:-At risk for falls;-The resident had a non injury fall on 01/08/25;-The resident had a non injury fall on 04/18/25;-Used bilateral cane rails for bed mobility and positioning.Review of the resident's POS dated January 2026 showed an order for bilateral cane rails for bed mobility and positioning.Observation on 1/6/26 at 2:06 P.M., showed:-The resident lying in bed;-Both bilateral cane rails in the up position at the head of the bed.Observation on 1/7/26 at 10:22 A.M., showed:-The resident lying in bed;-Both bilateral cane rails in the up position at the head of the bed.3. Review of Resident #4's admission MDS dated [DATE], showed:-Severe cognitive impairment;-The resident had delusions;-The resident used side rails;-The resident required set up help with bed mobility;-History of falls prior to admission;-Diagnoses included atrial fibrillation (an irregular heartbeat), high blood pressure and Benign Prostatic Hyperplasia (BPH) enlargement of the prostate gland. Review of the resident's care plan dated 12/27/25, showed:-Impaired thought process related to dementia;-The care (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265821	A. Building B. Wing	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire Senior Living Excelsior Springs	1003 Meadowlark Lane Excelsior Springs, MO 64024

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	plan did not address the use of side rails.Review of the resident's bed rail assessment dated [DATE] showed:-Bilateral side rails used;-No height or weight of the resident was found on the assessment;-No documentation to confirm the bed rails installed were appropriate to the size and weight of the resident.Review of the resident's POS dated January 2026 showed:-Order for bilateral cane rails for bed mobility and positioning.Observation on 1/6/26 at 1:06 P.M., showed:-The resident lying in bed;-Both bilateral cane rails in the up position at the head of the bed.Observation 1/7/26 at 09:22 A.M., showed:-The resident lying in bed;-Both bilateral cane rails in the up position at the head of the bed. During an interview on 01/07/26 at 10:53 A.M., Certified Nurse Aid (CNA) A said:-Residents used the bed rails for positioning and bed mobility;-The nurses took care of completing any bed entrapment assessments.During an interview on 01/07/26 at 11:03 A.M., Licensed Practical Nurse (LPN) A said:-The residents used bed rails to get in and out of bed;-Side rail evaluations were completed by the MDS Coordinator or the Director of Nursing (DON);-The Maintenance Director installed the bed rails after the evaluations were completed.During an interview on 01/07/26 at 11:42 A.M., the MDS Coordinator said:-The admitting nurse notified the physician, and an order was obtained for a bed rail if the resident wanted one;-The nurses and therapy did the assessments for bed rails;-Maintenance installed the rails;-She had not heard of entrapment assessments.During an interview on 01/07/26 at 11:56 A.M., the Maintenance Director said:-He was responsible for the installation of bed rails;-He did not measure the resident beds before he/she installed the bed rails;-He did not do entrapment assessments.During an interview on 1/07/16 at 12:02 P.M., the DON said:-The process for bed rails started at admission;-If the resident wanted bed rails for bed mobility or therapy recommended the use of rails the resident would be evaluated by therapy and nursing;-Maintenance was responsible for the installation of the bed rails;-He was not aware of entrapment assessments for residents with side rails; -He expected residents with side rails to be safe from possible entrapment.During an interview 1/7/26 at 12:34 P.M., the supervisor of therapy said: -She did not know if the facility staff did bed entrapment assessments; -She expected residents with side rails to be safe from possible entrapment.During an interview on 1/08/16 at 10:43 A.M., the Administrator said:-She was not aware the facility policy included entrapment assessments;-The facility staff completed side rail assessments, but the height, weight and dimensions of the bed were not part of the assessment;-He expected residents with side rails to be safe from possible entrapment.

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation interview and record review the facility staff failed to complete inspection of bed frames, mattresses and bed rails as part of a regular maintenance program to identify areas of possible entrapment for three of 18 sampled residents (Resident #51, #4 and #24). The facility census was set 78.1. Review of Resident #51's quarterly Minimum Data Set (MDS), a federally mandated instrument completed by facility staff dated 08/05/25 showed:-No cognitive impairment;-Dependent on staff for toileting and bed mobility;-Incontinent of bowel and bladder;-Two or more falls with injury since admission;-Diagnoses included Multiple Sclerosis (MS) a chronic autoimmune disease that can cause high cholesterol and depression.Review of the resident's care plan dated 01/04/26 showed:-Diagnosis of MS;-At risk for falls;-The resident had a non injury fall on 09/23/25;-The resident had a fall with injury on 01/01/26; -Used bilateral cane rails for bed mobility and positioning.Review of the resident's Physician's Order Sheet (POS) dated January 2026 showed:-Order for bilateral cane rails for bed mobility and positioning.Review of the resident's nurse's notes showed:-12/31/25 5:30 P.M., the resident was observed on the floor by the staff. The resident's right arm was caught behind him/her with his/her back to the dresser; -12/31/25 at 6:56 P.M., staff assisted the resident up in bed. The resident said he/she reached off the side of the bed to get something off the floor and his/her shoulder got caught in the bed rail.Review of the resident's medical record showed:-No documentation that an inspection of the bed frame and mattress had been done prior to the installation of bed rails;-No documentation that a regular and ongoing inspection of the bed frame, mattress, and bed rails, to identify areas of possible entrapment had been done. Observation on 1/6/26 at 3:11 P.M., showed:-The resident lying in bed and yelling for the staff;-Both bilateral cane rails in the up position at the head of the bed.Observation and interview on 1/7/26 at 10:48 A.M., showed:-The resident lying in bed;-Both bilateral cane rails in the up position at the head of the bed;-The resident said the rails helped him/her get out of bed.2. Review of Resident #4's quarterly MDS dated [DATE] showed:-Severe cognitive impairment;-Dependent on staff for toileting and bed mobility;-One fall with injury since admission;-Diagnoses included heart failure, high blood pressure and anemia.Review of the resident's bed rail assessment dated [DATE] showed:-History of falls;-Bilateral assist bars used;-No height or weight of the resident was found on the assessment;-No documentation to confirm the bed rails installed were appropriate to the size and weight of the resident.Review of the resident's care plan dated 12/23/25 showed:-At risk for falls;-The resident had a non injury fall on 01/08/25;-The resident had a non injury fall on 04/18/25;-Used bilateral cane rails for bed mobility and positioning.Review of the resident's POS dated January 2026 showed:-Order for bilateral cane rails for bed mobility and positioning.Review of the resident's medical record showed:-No documentation that an inspection of the bed frame and mattress had been done prior to the installation of bed rails;-No documentation that a regular and ongoing inspection of the bed frame, mattress, and bed rails, to identify areas of possible entrapment had been done. Observation on 1/6/26 at 2:06 P.M., showed:-The resident lying in bed;-Both bilateral cane rails in the up position at the head of the bed.Observation on 1/7/26 at 10:22 A.M., showed:-The resident lying in bed;-Both bilateral cane rails in the up position at the head of the bed.3. Review of Resident #4's admission MDS dated [DATE], showed:-Severe cognitive impairment;-The resident had delusions;-The resident used side rails;-The resident required set up help with bed mobility;-History of falls prior to admission;-Diagnoses included atrial fibrillation (an irregular heartbeat), high blood pressure and Benign Prostatic Hyperplasia (BPH) enlargement of the prostate gland. Review of the resident's care plan dated 12/27/25, showed:-Impaired thought process related to dementia;-The care plan did not address the use of side rails.Review of the resident's bed rail assessment dated [DATE] showed:-Bilateral side rails used;-No height or weight of the resident was found on the (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	assessment;-No documentation to confirm the bed rails installed were appropriate to the size and weight of the resident.Review of the resident's POS dated January 2026 showed:-Order for bilateral cane rails for bed mobility and positioning.Review of the resident's medical record showed:-No documentation that an inspection of the bed frame and mattress had been done prior to the installation of bed rails;-No documentation that a regular and ongoing inspection of the bed frame, mattress, and bed rails, to identify areas of possible entrapment had been done. Observation on 1/6/26 at 1:06 P.M., showed:-The resident lying in bed;-Both bilateral cane rails in the up position at the head of the bed.Observation 1/7/26 at 09:22 A.M., showed:-The resident lying in bed;-Both bilateral cane rails in the up position at the head of the bed. During an interview on 01/07/26 at 10:53 A.M., Certified Nurse Aid (CNA) A said:-Residents used the bed rails for positioning and bed mobility;-The nurses took care of completing any bed entrapment assessments;-The maintenance department took care of installing the bed rails;-He/She did not know anything about bed inspections.During an interview on 01/07/26 at 11:03 A.M., Licensed Practical Nurse (LPN) A said:-The Maintenance Director installed the bed rails after the evaluations were completed;-He/She did not know if bed inspections or were done or not.During an interview on 01/07/26 at 11:42 A.M., the MDS Coordinator said maintenance installs the rails. If there are bed inspections and measurements to take that would be maintenance department's responsibility.During an interview on 01/07/26 at 11:56 A.M., the Maintenance Director said:-He was responsible for the installation of bed rails;-He did not measure the resident beds before he/she installed the bed rails;-He did not do entrapment assessments;-He did not have ongoing inspection process for measuring the bed frame, mattress, and bed rails, to identify areas of possible entrapment;-Residents should be free from the risks of entrapment.During an interview on 1/07/16 at 12:02 P.M., the DON said:-The process for bed rails started at admission;-Maintenance was responsible for the installation of the bed rails;-He was not aware of entrapment assessments for residents with side rails; -He was not aware of an ongoing process for measuring the bed frame, mattress, and bed rails, to identify areas of possible entrapment;-Residents should be safe and free from the risk of entrapment.During an interview on 1/08/16 at 10:43 A.M., the Administrator said:-She was not aware the facility had to do entrapment assessments;-The facility did side rail assessments, but the height, weight and dimensions of the bed were not part of the assessment;-The facility did not have an ongoing process for measuring the bed frame, mattress, and bed rails, to identify areas of possible entrapment and she expected residents with side rails to be safe from possible entrapment.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review the home failed to store all drugs and biologicals under proper temperature controls, when the facility was unable to provide a record that the refrigerator temperature in the Certified Medication Technician (CMT) medication room had been monitored to ensure medication was being stored at the proper temperature. The facility census was 78. The facility did not provide a medication storage policy. Observation of the medication room labeled as the CMT medication room (Certified Medication Technicians) on 01/06/2026 at 3:20 P.M. showed:-No refrigerator temperature log sheet on refrigerator and no logbook available in medication room;-The freezer compartment of the refrigerator had ice buildup on it and extending past the edges of the compartment;-Contents of the refrigerator included: two Mighty Shakes (a nutritional supplement used in individuals needing supplemental nutrition) and Arformoterol (a medication used for long-term maintenance treatment of chronic obstructive pulmonary disease) for Resident #9. During an Interview on 01/06/2026 3:20 P.M. CMT C said:- He/she does not check the refrigerator temperature and was not sure where the log for the refrigerator temperatures was kept;- He/she was not sure how long ice had been built up in the freezer compartment of the medication refrigerator. During an Interview on 01/06/2026 at 3:30 P.M. the Administrator said:- The medication refrigerator temperature log was usually kept on the counter in the CMT medication room above the medication refrigerator;- The night shift CMT is responsible for checking the medication refrigerator temperature;- She is not sure how long the ice had been built up in the freezer compartment. During an Interview on 01/08/2026 at 11:15 A.M. Registered Nurse (RN) A said the medication refrigerator temperature should be checked every shift. During an Interview on 01/08/2026 at 11:55 A.M. CMT B said: - He/she does not check the medication refrigerator temperature and was not sure who was responsible for that task;- He/she was not aware of ice built up in the freezer compartment of the medication refrigerator. During an Interview on 01/08/2026 at 12:55 P.M. the Director of Nursing (DON) said the medication refrigerator temperature should be checked and recorded every night.