STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265182	A. Building B. Wing	12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ascend at Aurora	1700 South Hudson Avenue Aurora, MO 65605

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to protect residents from misappropriation of property when staff could not account for two residents' (Resident #1 and #2) cards of controlled medications (narcotics) that had been in the possession of the facility. The facility census was 60.The Administrator and former Director of Nursing (DON) were notified on 11/23/25 of the missing medications. The facility completed an audit of resident medications, completed in-servicing of licensed staff who were involved in medication pass and medication storage, and notified families and physicians of the missing medications. The noncompliance was corrected 11/26/25. Review of the facility's policy Identifying Exploitation, Theft and Misappropriation of Resident Property, dated October 2025 showed the following:-As part of the abuse prevention strategy, volunteers, employees and contractors hired by this facility are expected to be able to recognize exploitation of residents and misappropriation of resident property;-Exploitation, theft and misappropriation of resident property are strictly prohibited;-Misappropriation of resident property means the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent;-Examples of misappropriation of resident property include drug diversion (taking the resident's medication;-Staff and providers are expected to report suspected exploitation, theft or misappropriation of resident property. Review of the facility's policy Controlled Substances, reviewed October 2025, showed the following:-The facility shall comply with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of Schedule II and other controlled substances;-Only authorized nursing staff and/or pharmacy personnel shall have access to Schedule II controlled drugs maintained on premises;-The Director of Nursing Services (DNS) will identify staff members who are authorized to handle controlled substances;-Controlled substances must be counted upon delivery. The nurse receiving the medication, will count the controlled substances to ensure the right quantities are there. Authorized personnel will sign for delivery. Any discrepancies will be reported to pharmacy and Director of Nursing (DON);-Nursing staff must count controlled medications at the end of each shift. The nurse coming on duty and the nurse going off duty must make the count together. They must document and report any discrepancies to the Director of Nursing Services;-Reconciliation of controlled medications shall include number of cards and pills in each card;-The DNS shall investigate any discrepancies in narcotics reconciliation to determine the cause and identify and responsibility parties, and shall give the Administrator a written report of such findings. Review of the facility's policy titled Discarding and Destroying Medications, reviewed October 2025, showed the following:-Medications will be disposed of in accordance with federal, state and local regulations governing management of non-hazardous pharmaceuticals, hazardous waste and controlled substances;-All unused controlled substances shall be retained in a securely locked area with restricted access until disposed of;-Schedule II, III and IV (non-hazardous) controlled substances will be disposed of in accordance with (continued on next page)

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

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	state regulations and federal guidelines regarding disposition of non-hazardous controlled medications. 1. Review of the facility's investigation summary, dated 12/01/25, showed the following:-On Sunday, 11/23/25 at 12:42 A.M., the DON was notified by an agency Licensed Practical Nurse (LPN) that there was potentially missing/misplaced narcotics;-The DON alerted the Administrator on Sunday morning around 7:00 A.M. indicating that the facility had a potential medication error issue. The Administrator told the DON to meet her at the facility to investigate the allegation;-The DON and Administrator met at the facility around 9:00 A.M. This is when the DON mentioned to Administrator that the facility may be missing some controlled medications;-The DON told the Administrator that the regional team was notified and that she self-reported the potential allegation to the state;-The Administrator instructed the DON to investigate the allegation gather facts by auditing each chart, order, and medication cart, interview and gather staff statements and to report back to her if indeed medications were missing and where and who may be responsible for it;-On Tuesday morning, the regional team came in for a weekly visit and was made aware that there was an ongoing investigation into potentially missing narcotics;-The regional team brought in an external registered nurse (RN) to assist with the investigation as well;-Investigational findings showed all residents received their pain medications as ordered, every day, and every shift. The medication oxycodone/acetaminophen (APAP) (opioid pain medication) tablet 10-325 (30 tablet) cards that belonged to Resident #1 and Resident #2 that were reported missing, were not located. The narcotic count sheet matching the missing cards was provided by the DON and marked and co-signed as destroyed. 2. Review of Resident #1's face sheet (admission data) showed the following:-admission date of 12/18/23;-Diagnoses include morbid obesity, high blood pressure, and schizophrenia (a mental health condition that affects how people think, feel and behave). Review of the resident's care plan, dated 12/18/23, showed the following:-The resident had arthritis pain;-Staff should monitor, record, and report to the nurse of the resident complaints of pain or requests for pain treatment.Review of the resident's current Physician Order Sheet (POS) showed an order, dated 05/27/25, for oxycodone-acetaminophen (opioid pain medication) oral tablet 10-325 milligrams (mg); staff to give one tablet by mouth (PO) every four hours for pain related to secondary osteoarthritis (arthritis of the joints). Review of the resident's November 2025 Medication Administration Record (MAR) showed an order, dated 05/27/25, for oxycodone-acetaminophen oral tablet 10-325 milligrams (mg); staff to give one tablet by mouth (PO) every four hours for pain related to secondary osteoarthritis.Review of the resident's annual Minimum Data Set (MDS-a federally mandated assessment tool completed by facility staff), dated 11/22/25, showed the following:-Moderately impaired skills;-He/she received scheduled pain medications;-He/she had pain almost constantly;-He/she received opioid medication. Review of the resident's individual controlled substances record showed the following:-An order for the resident's oxycodone-acetaminophen tablet 10-325 mg for one tablet PO every four hours;-Date received of 11/19/25 by a staff member with a count of 30;-Disposition of unused drug showed as destroyed, dated 11/23/25 for a quantity of 30;-Authorized signature of the former Director of Nursing (DON) and Certified Medication Technician (CMT) A. Review of the facility's destruction log binder did not show a destruction sheet for the resident's oxycodone. During an interview on 12/09/25, at 11:30 A.M. the Administrator said the resident's missing card of oxycodone was not found. During an interview on 12/09/25, at 1:06 P.M., CMT A said the following:-The facility did not have the 30-count card of the oxycodone for the resident;-He/she did not destroy the oxycodone for the resident;-The former DON asked him/her to sign the bottom of the narcotic sheet for the resident's oxycodone and said it was taken care of. The narcotic sheets did not have destroy, a date, or other information written on the it. During a phone interview on 12/09/25, at 1:40 P.M., the former (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	DON said the following:-On 11/23/25, after midnight, the night agency nurse texted her that he/she noticed a bundle of narcotic cards bundled together with another resident's card in the middle of the oxycodone cards and a card of oxycodone was missing for the resident; -She came to the facility on [DATE] and informed the Administrator that staff could not find the narcotic cards for the resident;-She did not destroy the resident's oxycodone. The resident's oxycodone was missing;-She thought if she wrote missing or stolen on the paper, it would be wrong, and should not had written destroyed on the paper;-She had not been trained as a DON, and it was her mistake writing destroyed on the bottom of the narcotic sheets.During an interview on 12/10/25 at 2:33 P.M., Licensed Practical Nurse (LPN) E said around 4:30 A.M., on 11/24/25, he/she called the Administrator and said there were cards of missing narcotics. The Administrator said she would notify the former DON. 3. Review of Resident #2's face sheet showed the following:-admission date of 10/20/25;-Diagnoses included anxiety disorder, low back pain, major depressive disorder, and high blood pressure. Review of the resident's care plan, dated 10/26/25, showed the following:-The resident had pain;-Staff to monitor, record and report to the nurse of the resident's complaints of pain or requests for pain treatment. Review of the resident's admission MDS, dated [DATE], showed the following:-Cognitive skills intact;-The resident received scheduled pain medication;-The resident had pain frequency almost constantly;-The resident received an opioid medication. Review of the resident's current POS showed an order, dated 11/03/25, for Percocet oral tablet 10-325 (oxycodone with acetaminophen); for staff to give one tablet PO every four hours for pain. Review of the resident's November 2025 MAR showed an order, dated 11/03/25, for Percocet oral tablet 10-325; for staff to give one tablet PO every four hours for pain. Review of the resident's individual controlled substances record showed the following:-An order for oxycodone/APAP tablet 10-325 mg;-Date received 11/07/25, no staff signature for received by;-Amount received of 30;-Disposition of unused drug: destroyed-Date: 11/23/25;-Quantity 30;-Authorized signature of the former DON and CMT A. Review of the facility's destruction log binder did not show a destruction sheet for the resident's medication. During an interview on 12/09/25, at 11:30 A.M., the Administrator said the resident's missing card of oxycodone was not found. During an interview on 12/09/25, at 1:06 P.M., CMT A said the following:-The facility did not have the 30-count card of the oxycodone for the resident;-He/she did not destroy the oxycodone for the resident;-The former DON asked him/her to sign the bottom of the narcotic sheet for the resident's oxycodone and said it was taken care of. The narcotic sheets did not have destroy, a date, or other information written on the it. During a phone interview on 12/09/25, at 1:40 P.M. the former DON said the following:-On 11/23/25 after midnight, the night agency nurse texted her that he/she noticed a bundle of narcotic cards bundled together with another resident's card in the middle of the oxycodone cards and a card of oxycodone was missing for the resident; -She came to the facility on [DATE] and informed the administrator that staff could not find the narcotic card for the resident;-She did not destroy the resident's oxycodone. The resident's oxycodone was missing;-She thought if she wrote missing or stolen on the paper, it would be wrong, and she should not had written destroyed on the paper;-She had not been trained as a DON, and it was her mistake writing destroyed on the bottom of the narcotic sheets. During an interview on 12/10/25, at 2:33 P.M, LPN E said around 4:30 A.M., on 11/24/25, he/she called the administrator and said there were two cards of missing narcotics. The Administrator said she would notify the former DON. 4. During an interview on 12/09/25, at 10:20 A.M., RN B said the following:-Nurses administer the narcotic liquids and the CMTs administer the narcotic tablets;-Narcotic counts are counted before and after shift;-Staff should notify the DON if a medication count is not correct;-Two nurses destroy medications. During interviews on 12/09/25, at 10:29 A.M. and 11:15 A.M., CMT C said the (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	following:-CMTs administer the narcotic tablets;-Staff count the narcotic medications each shift change;-Staff should notify the DON if a medication narcotic count is not correct;-Staff wrap the narcotic sheet with the medication card and now place it in the black box for the nurses to destroy. CMTs did not destroy medications;-He/she would not sign a medication document if he/she did not observe the medication destroyed. During an interview on 12/09/25, at 1:06 P.M., CMT A said the following:-Staff count narcotic cards and narcotics each shift change;-Staff should report to the DON if a narcotic count is not correct and not leave until investigated;-Two staff should destroy medications at the same time;-Staff destroy medications if a resident passed away or the medication was discontinued. Staff should subtract the card from the number of total cards and take to the charge nurse;-Staff should sign the bottom of the narcotic sheet after observation of a destroyed medication;-He/she considered a missing medication to be misappropriation of property.During an interview on 12/10/25, at 2:33 P.M., LPN E said the following-Nursing staff count should count narcotics each shift change;-Staff should count and check to make sure the narcotics match the card and sheet each shift;-On Saturday 11/23/25, night into Sunday morning 11/24/25, he/she was with an agency nurse who notified him/her at midnight that he/she went through the narcotic cards to verify he/she signed everything and saw two bundles of narcotics bundled together with a rubber band;-He/she witnessed each of the resident's one card of oxycodone missing;-Around 4:30 A.M., on 11/24/25, he/she called the Administrator and said there were two cards of missing narcotics. The aAdministrator said she would notify the former DON;-Staff should not write destroy on the bottom of a narcotic sheet if they are missing or stolen. During an interview on 12/09/25, at 10:57 A.M., RN D said the following:-Nurses administer the medications for residents on hospice and narcotic liquids;-CMTs administer the narcotic tablets;-Staff count the narcotics on shift change to ensure the cards and sheets match;-Staff should notify the DON if a narcotic count is incorrect;-He/she considers misappropriation of property if a medication count is incorrect. During an interview on 12/09/25, at 11:30 A.M., the interim DON said the following:-She would consider missing medications misappropriation of property;-Staff should do narcotic counts before and after each shift;-Staff should notify the DON if a medication count is not accurate;-Nursing staff should sign the document of the medication destroyed, staff should observe the destroyed medication and sign as witnesses;-Nursing staff should document on the resident's sheet in the destruction log binder when a medication is destroyed;-She expected staff to witness destruction of a medication before signing the paper;-Staff should not write destroy on a paper if a medication is not destroyed. During an interview on 12/09/25, at 1:26 P.M., the corporate Regional Director of Operations (DOP) said the following:-CMT A said he/she did not witness destruction of the resident's oxycodone;-CMT A said he/she thought he/she was signing the bottom of the narcotic sheets for a medication correction;-The former DON said she did not know how else to correct it. During an interview on 12/09/25, at 11:30 A.M., the Administrator said the following:-She considered medications not found as misappropriation;-She did not know the narcotic sheets had destroyed written on it;-The former DON called her that the two cards of oxycodone were missing;-The missing narcotics were never found;-She expects staff to witness destruction of a medication before signing the paper. Complaint 2679395

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interviews and record review, the facility failed to ensure all allegations of misappropriation of property were reported within 24 hours to the State Survey Agency (Department of Health and Senior Services-DHSS) when staff failed to report timely when they discovered two missing cards of narcotics for two residents (Resident #1 and Resident #2). The facility census was 60. The Administrator and former Director of Nursing (DON) were notified on 11/23/25 of the missing medications. It was discovered on 11/26/25 are report to DHSS had not been made. The facility completed in-servicing of staff and audits of records. The noncompliance was corrected on 11/26/25. Review of the facility's policy Identifying Exploitation, Theft and Misappropriation of Resident Property, dated October 2025 showed the following:-As part of the abuse prevention strategy, volunteers, employees and contractors hired by this facility are expected to be able to recognize exploitation of residents and misappropriation of resident property;-Exploitation, theft, and misappropriation of resident property are strictly prohibited;-Misappropriation of resident property means the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent;-Examples of misappropriation of resident property include drug diversion (taking the resident's medication);-Staff and providers are expected to report suspected exploitation, theft or misappropriation of resident property. 1. Review of the facility's investigation summary, dated 12/01/25 showed the following:-On Sunday, 11/23/25 at 12:42 A.M., the Director of Nursing (DON) was notified by an agency Licensed Practical Nurse (LPN) that there was potentially missing/misplaced narcotics;-The DON alerted the Administrator on Sunday morning around 7:00 A.M. indicating that the facility had a potential medication error issue;-The Administrator told the DON to meet her at the facility to investigate the allegation;-The DON and Administrator met at the facility around 9:00 A.M. This is when the DON mentioned to the Administrator that the facility may be missing some controlled medications;-The DON told the Administrator that the regional team was notified and that she self-reported the potential allegation to the state;-On Tuesday (11/25/25) morning, the regional team came in for a weekly visit and was made aware that there was an ongoing investigation into potentially missing narcotics. When the regional team discussed the allegation and investigation with the Administrator and DON, the Administrator realized that the DON did not report the allegation to the regional team;-The DON then admitted that she did not self-report this allegation to the state;-Investigational findings showed all residents received their pain medications as ordered, every day, and every shift. The medication oxycodone/APAP (opioid pain killer) tablet 10-325 (30 tablets) that belonged to Resident #1 and Resident #2 that were reported missing, were not located. Review of DHSS records showed the allegation of misappropriation was reported on 11/26/25. During an interview on 12/09/25, at 10:20 A.M., Registered Nurse (RN) B said the following:-Staff should notify the DON if a medication count is not correct;-Staff should report to DHSS in four hours if narcotics are missing or unaccounted for. During an interview on 12/09/25, at 10:29 A.M. and 11:15 A.M., Certified Medication Tech (CMT) C said staff should notify the DON if a medication narcotic count is not correct. Staff should report to DHSS of a misappropriation of property.During an interview on 12/09/25, at 1:06 P.M., CMT A said the following:-Staff should report to the DON if a narcotic count was not correct and not leave until investigated;-He/she considers a missing medication to be misappropriation of property;-Staff should report to the DON of any missing medications and to DHSS within two hours. During an interview on 12/09/25, at 10:57 A.M., RN D said the following:-Staff should notify the DON if a narcotic count is incorrect;-Staff should report to DHSS within two hours of misappropriation of property;-He/she considers misappropriation of property if a medication count is (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	incorrect. During an interview on 12/09/25, at 1:40 P.M., the former DON said the following:-She and the Administrator decided it was not a two-hour reportable report due to it was not abuse;-She considered missing medications a misappropriation of property. During an interview on 12/9/25 at 11:30 A.M. the interim DON said the following:-She would consider missing medications misappropriation of property;-Staff should report to DHSS within two hours of misappropriation of property.During an interview on 12/09/25, at 1:26 P.M., the corporate Regional Director of Operations said the allegation of the missing narcotics should had been reported within 24 hours. During an interview on 12/09/25, at 11:30 A.M., the Administrator said the following:-She considered medications not found as misappropriation;-Staff should report to DHSS within 24 hours of a misappropriation of property;-She believed the former DON sent the allegation of misappropriation of property to DHSS on Sunday 11/23/25. Complaint 2679395