STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265307	A. Building B. Wing	09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire Senior Living Webb City	2077 Stadium Drive Webb City, MO 64870

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 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. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to ensure all allegations of possible abuse were reported immediately to manage and with in two hours to the Survey Agency (DHSS - Department of Health and Senior Services) when staff failed to report and an allegation of abuse involving one resident (Resident #1) until the following day. The facility census was 101. Review of the facility policy Abuse and Neglect, dated 10/24/22, showed the following:-Each employee has an obligation to immediately report any incident or allegation that could constitute an instance of abuse or neglect, or an injury of unknown origin to the Director of Nursing (DON) or the department supervisor and that individual will notify the Administrator;-Each employee should report to the supervisor and follow-up with the supervisor to confirm it has been addressed. If not, the employee should make direct contact with the Administrator;-Any staff members that witnessed, suspected, or that is reported to, are personally obligated to initiate protection and report to supervisor immediately.1. Review of Resident #1's face sheet (admission information at a glance) showed the following:-admission date of 09/11/23;-Diagnoses included fractured left hip with artificial hip joint, moderate dementia (progressive impairments in memory, thinking, and behavior which affects ability to carry out daily activities) with anxiety, type 2 diabetes mellitus (high blood sugar), chronic kidney disease, urinary tract infection, and chronic obstructive pulmonary disease (COPD - lung disease that blocks air flow and makes it difficult to breathe). Review of the resident's care plan, revised 8/23/25, showed the following:-The resident had impaired cognition/decision making ability and impaired communication related to dementia. The resident exhibited behaviors of delusions;-Explain care and procedures before and during care; -Observe for understand, and repeat information as needed;-Provide consistent caregivers as possible;-Provide simple cues, prompts, and reminders as needed;-Speak name or touch resident so they know they are being addressed;-Allow opportunity to make choices and participate in care;-Do not argue with resident;-Identify causes for behaviors and reduce factors that may provoke behaviors;-Impaired cognition;-Explain care and procedures before and during care;-Observe for changes in cognition;-Observe resident when restless, hungry, thirsty, need to use the bathroom, pain, and provide care needed;-Assist with decisions as needed and offer choices;-Provide cues, prompts, and reminders as needed;-Touch and hugs as appropriate.During interviews on 09/09/25, at 1:34 P.M., and on 09/10/25, at 10:55 A.M., Nurse Aide (NA) E said on 08/31/25, at around 4:30 A.M. to 5:00 A.M., while doing their last rounds before shift change, he/she and Certified Nurse Aide (CNA) G went into the resident's room to provide incontinence care. CNA G turned on the light and asked the resident if they could provide care. When CNA G went to take off the incontinence brief, the resident was startled, and grabbed CNA G's arm and then hit his/her arm. CNA G grabbed the resident's hands and wrists and crossed them on his/her chest to hold him/her down. CNA G had an aggressive mean voice with the resident for hitting him/her. CNA G held the resident's hands across his/her chest for about a minute. NA E didn't know what to say or do. The resident refused to let them change him/her and they left without changing him/her. He/she knows now they should have gone and told the nurse about the resident refusing and being aggressive, and to try to go back later to the resident. He/she said, It didn't cross his/her mind to tell the charge nurse right away. He/she did think about it later and then told NA F the next night on 08/31/25 to 09/01/25. NA F told him/her that he/she should report this. Then NA F went ahead and made the report. He/she was to report to the charge nurse and then make a paper report. NA F told RN A the next day before he/she got off work. He/she did not know the time frame to report an allegation of abuse and neglect and did not know the time frame to report to the state.Review of the resident's progress note dated 09/01/25, at 7:15 P.M., showed there was an allegation of abuse that had been made about the resident. The Staffing Development Coordinator (RN) A and Licensed Practical Nurse (LPN) B assessed the resident, suspended the staff member, and notified the physician, Administrator, and durable power of attorney (DPOA). Review of DHSS records showed the facility self-reported the allegation of physical abuse on 09/01/25, at 7:24 P.M. Review of the facility's written investigation, dated 09/01/25, showed it was reported that CNA G forcibly held down the resident's hands.During an interview on 09/09/25, at 11:25 A.M., CNA D said if he/she noticed any bruising on a resident, he/she would automatically tell the nurse and chart this since the aides do chart skin for redness and bruising and where it's located. If he/she saw abuse, he/she would intervene and go let nurse know. NA E mentioned the event to NA F who was told to report to RN A. NA E was a new nurse aide and said he/she didn't know who to report to. If staff see something like abuse, staff were to tell the nurse who was to report this to the Administrator. They were to report any abuse or neglect within two hours to the