STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265309	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire Senior Living Joplin	2218 W 32nd Street Joplin, MO 64804

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility failed to provide care per standards of practice when staff failed to document assessment, monitoring, and physician notification of a fall with injury for one resident (Resident #1) resulting in staff on following shifts not being aware of the need of fall follow-up monitoring. The facility census was 110. Review of the facility's policy, Fall Prevention Program, dated 10/01/25, showed the following: -A "fall refers to unintentional change in position coming to rest on the ground, floor or onto the next lower surface (e.g., onto a bed, chair, or bedside mat) or the result of an overwhelming external force (e.g., a resident pushes another resident). An intercepted fall occurs when the resident would have fallen if they had not caught themselves or had not been intercepted by another person - this is still considered a fall. If there is a loss of balance during supervised therapeutic interventions and the resident comes to rest on the ground, floor, or next lower surface despite the clinician's effort to intercept the loss of balance, it is considered a fall; -A near miss which is also considered a fall, is when a resident would have fallen if someone else had not caught the resident from doing so; -When any resident experiences a fall, the facility will assess the resident, complete a post-fall assessment, complete an incident report, notify physician and family, review the resident's care plan and update as indicated, document all assessments and actions, and obtain witness statements in the case of injury. 1. Review of Resident #1's face sheet (a document that gives a resident's information at a quick glance) showed the following:-admission date of 11/24/23;-Diagnoses included unspecified dementia, severe, without behavioral disturbance; chronic atrial fibrillation (rapid, irregular heartbeat), obesity, depression, insomnia, and repeated falls.Review of the resident's care plan, dated 04/22/24 and edited on 10/02/25, showed the following: -The resident is at risk of falls;-The resident required assistance to get out of bed;-Fall mat beside the bed and staff to assist with sitting in a chair in the common areas;-Encourage non-skid footwear;-Observe for changes in condition that may warrant increased supervision/assistance and notify the physician;-Remind resident to ask staff for assistance with walking;-The resident has the potential for complications due to anticoagulant (blood thinner) therapy;-Observe for abnormal bleeding, increased bleeding, hematuria (blood in urine), bleeding gums, black/tarry stools, and hematemesis (vomiting of blood). Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 12/01/25, showed the following: -Moderate cognitive impairment;-Moderate assistance for transfers and walking;-The resident has had no falls since the last assessment. Review of the resident's progress note dated 12/16/25, at 2:43 P. M., showed Registered Nurse (RN) A noted the resident had a hematoma (a collection of clotted blood outside of blood vessels, pooling in tissues, organs, or spaces, often from trauma, appearing as a deep bruise but more significant) on the right side of his/her head. Certified Nursing Aide (CAN) B said the resident fell out of bed two nights ago. The resident said a female helped him/her up and back into bed. The physician was notified via text Review of the resident's medical records showed staff did not document regarding a fall, injury, physician notification, assessment, or monitoring before 12/16/25. Review of the resident's record showed staff did not document a physician visit on 12/16/25 or 12/17/25. Observations on 12/18/25, at 11:00 A.M., showed the resident had a bruise on the right side of his/her forehead. The bruise had a purple spot about the size of a marble. Around the purple was a more yellowed bruising about the size of a tennis ball. During an interview on 12/18/25, at 11:00 A.M., the resident said the following: -He/she got the bruise on his/her head when he/she fell out of bed about two nights ago. A woman came in and looked him over after the incident and helped him back into bed;-The doctor saw him yesterday;-The bruise on his head no longer hurts. He/she did not remember any other assessments. During an interview on 12/18/25, at 1:53 P.M., CNA B said the following: -He/she noticed a bruise on the resident's forehead on 12/16/25. Another staff had just gotten him/her back to his/her room and asked about the bruise;-The resident said he/she had fallen on 12/14/25 at night;-The resident did not say who helped him/her up or who assessed him/her;-He/she was not aware the resident had a fall prior to this. Generally, that is something that would be passed on in report;-He/she reported the bruise/fall to RN A;-RN A came in an assessed the resident;-RN A was also not aware the resident had a recent fall. During an interview on 12/18/25, at 3:21 P.M., RN A said the following: -On 12/16/25, CNA B made him/her aware that the resident had a bruise on his/her head;-The resident said it had happened two days ago. The resident said somebody helped him up. He/she checked neuros and checked his/her vital signs;-He/she did not see any documentation in the chart regarding a fall or where the bruise might be from. He/she started to investigate;-He/she spoke with RN D and Licensed