

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265333	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/03/2025
NAME OF PROVIDER OR SUPPLIER Aspire Senior Living Jonesburg		STREET ADDRESS, CITY, STATE, ZIP CODE 308 Cedar Avenue Jonesburg, MO 63351	

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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>18236</p> <p>Based on record review and interview, facility staff failed to ensure one resident (Resident #1) remained free from verbal and physical abuse when Certified Nursing Assistant (CNA A) threatened Resident #1 with rough treatment. The facility census was 60.</p> <p>The administrator was notified on 12/24/24 of past Non-Compliance which occurred on 12/24/24. On 12/24/24, staff notified the administrator they witnessed CNA A telling Resident #1 he/she would manhandle the resident if the resident did not cooperate with care. Staff immediately suspended CNA A, assessed the resident for injuries, and notified the required parties and agencies. The administrator terminated CNA A on 12/26/24. The administrator in-serviced all staff, on abuse and neglect policies and procedures by 12/30/24.</p> <p>1. Review of the facility's Abuse, Neglect, and Misappropriation Policy, dated 1/30/24, showed the purpose is to ensure each resident's right to be free from abuse, neglect, and corporal punishment of any type by anyone. Review showed abuse is a willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting harm, pain, or mental anguish. Willful is defined as the individual acting deliberately, not that the individual intended to inflict harm or injury.</p> <p>2. Review of Resident #1's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 10/18/24, showed staff assessed the resident as follows:</p> <ul style="list-style-type: none"> -Cognitive intact; -Diagnosis of Parkinson's disease, wedge compression fracture of the vertebra, pain, and vertigo; -Depressed mood several days of the week; -Moderate assistance needed to transfer from a bed to a chair, and go from sitting to standing position; -Impairment to both legs. <p>Review of the resident's plan of care, dated 11/1/24, showed staff assessed the resident as follows:</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Weakness and delayed response from Parkinson's disease;</p> <p>-Chronic pain due to compression fractures;</p> <p>-Risk of falling due to impaired balance and weakness;</p> <p>-Ability to transfer, walk in room, walk in corridor, toilet, maintain personal hygiene, has deteriorated due to progression of Parkinson's disease.</p> <p>Review of the facility's investigation summary, dated 12/24/24, showed staff documented the social worker observed CNA A threatening the resident with being manhandled and handling Resident #1 in an aggressive manner on 12/24/24. Review showed staff documented the resident said CNA A had handled him/her in a rough manner and him/her, he/she would manhandle him/her after the resident told CNA A he/she could not stand. Review showed the social worker documented he/she heard CNA A tell the resident twice he/she would manhandle the resident and witnessed CNA A handling the resident in an aggressive manner. Review showed staff documented CNA A was suspended pending investigation, and terminated 12/26/24.</p> <p>Review of the administrator written statement, dated 12/24/24 at 8:50 A.M. showed the administrator documented with the BOM present showed the resident said CNA A told him/her to get up, grabbed his/her legs, sat him/her up on the side of the bed and told him/her to stand. The resident told the CNA he/she couldn't stand, so the aide grabbed him/her and put him/her in the wheelchair. The aide then pushed him/her in the bathroom and asked him/her to hold the railing. When the resident said he/she couldn't grab the railings, the CNA grabbed him/her again and put him/her on the toilet. The resident said the CNA told him/her, he/she was going to be manhandled after he/she told the aide he/she could not stand. The resident said the aide was rough with him/her.</p> <p>During an interview on 1/3/25 at 10:42 A.M., the social worker said he/she was in the room of the resident assisting the resident's roommate when CNA A came in to assist Resident #1. Resident #1 said you are hurting me to CNA A, so CNA A stepped away, but when he/she returned CNA A told the resident we are going to try again, but if you don't try I'm going to manhandle you. Then CNA A grabbed the resident from the front under the resident's arms and moved him/her abruptly to his/her wheelchair causing the locked wheelchair to rock. CNA A then moved the wheelchair to the bathroom and tried to get the resident to hold the grab bars, but the resident could not reach the grab bars, so CNA A said I'm going to have to manhandle you again. CNA A then lifted the resident up from the chair by yanking his/her pants and abruptly pushed him/her torso down on the toilet seat without allowing the resident to pivot his/her feet. The social worker said he/she asked CNA A to leave.</p> <p>During an interview on 1/3/25 at 11:09 A.M., CNA A said he/she worked with the resident a few times and the resident could pivot his/her feet and stand with assistance. CNA A said the resident was resisting him/her as he/she was trying to get the resident out of bed, so he/she said to the resident, you have to help me or I will need to manhandle you. CNA A said he/she did not know why he/she said this, and it was not OK for him/her to do so. CNA A said he/she bear-hugged the resident to get him/her up from bed and placed the resident in the wheelchair. CNA A said he/she then took the resident to the bathroom and the resident was unable to hold the grab bar so he/she bear-hugged the resident again and lowered him/her to the toilet.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 1/3/25 at 11:47 A.M., the resident said the CNA who came in the room, him/her to get up. The resident said he/she told the CNA he/she cannot get up and the CNA said I'll just manhandle you. The resident said the CNA grabbed him/her under the arms, stood him/her up at the side of the bed and then shoved him/her back down on the bed. The resident did not remember how he/she got in the wheelchair. The resident said, I don't remember what happened in the bathroom, because I was crying so hard.</p> <p>MO00247019</p>		