STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265333	A. Building B. Wing	11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire Senior Living Jonesburg	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)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, facility staff failed to notify one resident's (Resident #1) out of one sampled resident representative in a timely manner when staff assessed the resident with an open area to the knee and bone protruding through the skin. The facility census was 59. The administrator was notified on 11/18/25 of Past Non-Compliance, which occurred on 10/06/25 when nursing staff failed to notify Resident #1's Power of Attorney (POA) of a change in condition to an old fracture to the right knee with new bone protrusion. Nursing staff completed in-service training on when and who to notify after a change in condition on 10/10/2025. 1. Review of the facility's policy titled Notification of Changes, dated 10/01/25, showed the purpose is to ensure the facility promptly informs the resident and notifies the resident representative when there is a change requiring notification. The facility must inform the resident and/or notify the resident's legal representative when there is a change requiring such notification. Circumstances requiring notification include; potential to require physician intervention, circumstances that require a need to alter treatment including new treatment, discontinuation of current treatment due to acute condition or exacerbation of chronic conditions.2. Review of Resident #1's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 9/16/25, showed staff assessed the resident as follows:-Severe Cognitive impairment;-Lower extremity impairment both sides;-Dependent on staff for transfers, toileting, and hygiene;-Diagnoses of Non-Alzheimer's Dementia.Review of the resident's nurse notes, dated 10/05/25 at 12:41 A.M., showed staff documented a 0.5 centimeter (cm) open area to the right knee with a white center, no odor or drainage noted. The nurse's note did not contain documentation the resident's representative had been notified of the open area to the knee. Review of the resident's nurse note, dated 10/06/25 at 1:22 A.M., showed staff documented a pink tinge drainage from the right knee dressing. Dressing removed, area cleansed, pinpoint hole noted with large amount of pink tinged drainage. Bone protruding under skin. New dressing applied. Resident yells out it hurts often, even when care is not being done. The nurse note did not contain documentation staff notified the resident representative of change in condition. Review of the resident's nurses note, dated 10/06/25 at 8:08 A.M., showed the assistant director of nursing (ADON) documented he/she notified the resident's physician the right femur fracture bone protruded through the skin and current pain management is not effective, new orders received. The nurse note did not contain documentation staff notified the resident representative of change in condition. Review of the resident's nurses note, dated 10/07/25 at 1:31 P.M., showed a new order for Keflex (antibiotic) 500 milligrams (mg) three times a day for five days due to wound.Review of the resident's nurses note, dated 10/07/25 at 3:33 P.M., showed the MDS coordinator documented he/she spoke with the resident's representative about the resident's status, discharge from Medicare services, and antibiotic due to wound infection.During an interview on 11/17/25 at 2:06 P.M., the DON said he/she is unsure why the charge nurse did not notify the resident's representative when the femur bone protruded through the resident's skin, but they should have. The resident's representative should have been notified as soon as possible. During an interview on 11/18/25 at 12:02 P.M., the ADON said when a resident has a change in condition the resident representative should be contacted as soon as possible. He/She said he/she does not have a good reason why the resident representative was not notified after the doctor was contacted for the resident's change in condition. He/She said he/she was so worried about the resident that is slipped his/her mind.During an interview on 11/18/25 at 1:20 P.M., the administrator said staff is expected to notify the resident representative promptly or immediately with a change in condition. Each situation is different but after a resident is assessed staff should notify the representative if there is a change. Complaint #2642026