

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 01/05/2026
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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>Based on interview and record review, facility staff failed to meet professional standards of practice when staff failed to complete weekly skin assessments for one resident (Resident #1) out of three sampled residents. The facility census was 62.1. Review of the facility's policy titled Skin Integrity, dated 01/30/24, showed the medical record will contain all documentation regarding assessment of skin. Review of the facility's policy titled Skin Observation, undated, showed a full body, or head to toe, skin observation will be conducted by a licensed or registered nurse upon admission/re-admission and weekly thereafter; The facility did not provide a policy for following physician's orders. 2. Review of Resident #1's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 09/25/25, showed staff assessed the resident with moderate cognitive impairment. Review of the resident's care plan, dated 12/29/25, showed staff assessed the resident with impaired cognition and at risk for skin breakdown and pressure ulcers. Review of the resident's Physician's Order Sheet (POS), dated 10/03/25, showed an order for weekly skin assessments every Friday on the evening shift. Review of the resident's nurse's notes, dated 12/21/25, showed staff documented a deep tissue injury (DTI) (intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration) on the resident's sacrum. Review of the resident's POS, dated 12/29/25, showed an order for weekly skin assessments every Monday on the night shift. Review of the resident's weekly skin assessment, dated December 2025, showed staff did not document they assessed the resident's skin on 12/05/25, 12/12/25, and 12/19/25. Review of the resident's POS showed orders: -On 01/02/26: Miconazole Nitrate Vaginal Cream 4% (an antifungal medication), mix with barrier cream (a skin protectant) and apply to buttock every shift and as needed; -On 01/02/26: Skin prep (a skin protectant) wipes to left heel every shift. Observation on 01/05/26 at 9:45 A.M., showed the resident in bed on a low air loss mattress. During an interview on 01/05/26 at 12:45 P.M., the MDS nurse said he/she does not see any weekly skin assessments completed for the resident from 11/28/25 through 12/21/25. The MDS nurse said the resident has an order for weekly skin assessments and they should have been completed during that time. The MDS nurse said the charge nurse is responsible to complete them and he/she does not know why they were not done. The MDS nurse said if something is not documented it was not completed, and staff are expected to follow all physician's orders. During an interview on 01/05/26 at 1:22 P.M., Registered Nurse (RN) A said the resident has a DTI on his/her sacrum and a pressure ulcer on his/her left heel. RN A said the DTI was found on 12/21/25 prior to the resident going to the hospital and the left heel has been an ongoing issue but he/she did not know the date it was found. RN A said both wounds were facility acquired. RN A said both wounds should be documented on the resident's skin assessment. RN A said prior to this most recent hospital stay on 12/22/25 the resident had multiple behaviors and was non-complaint with cares such as repositioning and wearing heel protectors. RN A said the charge nurse is responsible to complete the weekly skin assessments and document them in the resident's chart. RN A said he/she knows the resident has an order for weekly skin assessments and the computer</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 265333
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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>system automatically triggers the charge nurse to complete them. RN A he/she does not know why all the skin assessments were not completed but said they should have been. RN A said all physician's orders should be followed as this is what directs a resident's care. RN A said if an order is not followed it could lead to potential resident harm, like in this case wounds. During an interview on 01/05/26 at 1:58 P.M., the Director of Nursing (DON) said he/she expects staff to follow physician's orders as this is what directs a resident's care. The DON said the charge nurse is responsible to complete the weekly skin assessments on all residents and document them in the resident's chart. The DON said he/she was not aware the resident did not have a skin assessment documented from 11/28/25 through 12/21/25. The DON said if it is not documented it was not completed. The DON said the resident is non-compliant and if he/she refused a skin assessment the charge nurse should have documented that, as not documenting is not acceptable. The DON said the consequences of not following physician's orders can lead to potential outcomes or harm to the resident. During an interview on 01/05/26 at 2:20 P.M., the Administrator said he/she expects staff to follow all physician's orders as this is what tells the staff how to care for the resident and provide proper treatment or medications. The Administrator said the charge nurse is responsible to complete the weekly skin assessments and document them in the resident's chart timely. The Administrator said if something is not documented he/she can't say if it was completed or not. The Administrator said she was not aware staff didn't complete skin assessments on this resident from 11/28/25 through 12/21/25. The Administrator said staff should have completed and documented skin assessments per the physician's orders. The Administrator said not documenting the assessments is not acceptable. The Administrator said the consequences of not completing assessments can result in potential outcomes for the residents such as wounds like this. The Administrator said the DON, MDS, or himself/herself are responsible to oversee the nurse's and ensure things are completed and documented as ordered. The Administrator said he/she did not know why the assessments were not completed per the physician's orders but should have been.</p> <p>Complaint #2700450</p>		