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	05/12/2026

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. Based on interview and record review, facility staff failed to notify the physician after a change in condition for one resident (Resident #1) out of one sample residents when staff assisted the resident with positioning, heard a pop and the resident complained of pain. The facility census was 63.1. Review of the facility's Notification of Changes policy, dated 01/30/24, showed the facility must immediately inform the resident, consult with the resident's physician, and notify, consistent with his/her authority, the resident representative(s) when there is a significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications). 2. Review of the resident's care plan, dated 01/15/25, showed the resident had an Activity of Daily Living (ADL) self-care performance deficit related to a diagnosis of left sided paralysis and required two staff for transferring.Review of the facility report, dated 04/21/26, showed the Certified Nurse Aide (CNA) A documented he/she repositioned the resident by rolling him/her towards the wall, when he/she heard a pop. The resident immediately expressed pain, stating ouch and reported his/her leg hurt. The CNA immediately reported the incident to the charge nurse. The CNA documented the following morning, the resident was observed in his/her wheelchair and continued to report pain, so he/she again, reported the incident from the prior night to the charge nurse. The report did not contain documentation the physician was notified after the incident.Review of the resident's progress notes, dated 04/22/26, showed staff documented during the morning shift change report resident sitting in wheelchair by housekeeping office, anytime staff approached the resident, resident began yelling and cussing his/her left hip hurt. Staff documented the behavior was usual for resident to yell and cuss when in pain. The notes did not contain documentation staff contacted the physician after a change in condition. During an interview on 04/30/26 at 10:38 A.M., CNA A said he/she during the evening on 04/21/26, rolled the resident towards the wall, he/she heard a pop noise and the resident yelled out in pain. He/She immediately reported it to the Licensed Practical Nurse (LPN) B.During an interview on 04/30/26 at 10:49 A.M. LPN B said he/she did not recall if CNA A reported the incident to him/her because he/she was busy assisting a new admission. He/She said he/she did see the resident on 04/21/26 between 9:30 to 10:00 P.M. and he/she did complain about pain in his/her legs, but upon assessment, did not see any injuries. He/She said he/she did not contact the physician since the resident had a history of leg pain.During an interview on 04/30/26 at 1:14 P.M., administrator said he/she expected staff to contact the physician if the resident had a change in condition. He/She said the nurse should have contacted the physician after CNA A reported hearing a popping noise and the resident was in pain. 2993245

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, facility staff failed to safely transfer one resident (Resident #3) when staff failed to utilize two staff members while using a mechanical lift, the mechanical lift tipped over, which resulted in left femoral fractures, right femur fractures, a bruise to the forehead, and a T12 compression fracture (occurs when the 12th thoracic vertebra) required hospitalization. Facility staff failed to utilize two staff for bed mobility for one dependent resident (Resident #1) which resulted in a femur fracture. Facility staff failed to utilize two staff in a manner to assure resident safety for one resident (Resident #2) out of three sampled residents. The facility census was 63.1. Review of the facility's Safe Resident Handling and Transfers policy, dated 10/1/25, showed residents are handled and transferred safely to prevent or minimize risks for injury and provide and promote a safe, secure and comfortable experience for the resident while keeping the employees safe in accordance with current standards and guidelines. While manual lifting techniques may be utilized dependent upon the resident's condition and mobility, the use of mechanical lifts are a safer alternative and should be used. Staff will be educated on the use of safe handling/transfer practices and to include use of mechanical lift devise upon hire, annually and as the need arises or changes in equipment occur. Staff members are expected to maintain compliance with safe handling/transfer practices, failure to maintain compliance may lead to disciplinary action up to and including termination of employment.2. Review of Resident #3's Annual MDS, dated [DATE], showed staff assessed the residents as severely cognitively impaired and dependent on staff to transfer to and from a bed to a chair (or wheelchair).Review of the resident's care plan, dated 04/09/26, showed the resident had limited physical mobility related to contractures, stroke and weakness and required assistance from one staff for locomotion. The care plan did not provide directions to staff for transfer assistance.Observation on 04/30/26 at 12:15 P.M., showed the Social Service Director (SSD) and CNA D entered the resident room to provide care to the resident. CNA D operated the lift and transferred the resident from the bed over to the wheelchair, while the SSD stood next to the wheelchair. The resident swung in the air during the transfer from the bed to the chair.During the interview on 04/30/26 at 12:20 P.M., the SSD said staff are educated to use two staff when transferring a resident with a mechanical lift. He/She said one staff should be operating the lift and the other staff would be either by the bed or the wheelchair to safely to lower the resident. He/She said he/she did notice the resident was moving a little bit while elevated in the sling above the floor without being guided.During an interview on 04/30/26 at 12:22 P.M., CNA D said two staff members are required to transfer a resident when using a mechanical lift. He/She said one person operates the lift and the other stands by the wheelchair and guides the resident while lowering into the chair. He/She said he/she was not trained on one staff guiding the resident during a transfer.Review of the resident's progress notes, dated 05/2/26 at 6:00 A.M., showed staff documented a CNA called for the nurse to come to the resident's room. Resident on floor next to his/her bed with mechanical lift turned onto its side next to roommate's bed. Staff documented approximate four-centimeter bruise to the residents' mid forehead with small amount of blood draining. Resident complained of lower extremity pain with no injury noted at this time. Emergency Medical services in route, residents taken to hospital. Review of the resident's hospital progress note, dated 05/02/26, showed staff documented the resident fell from mechanical lift which resulted in a facture of femoral shaft, left, a fracture of proximal end of right femur, a bruise to the forehead, T12 compression fracture, fracture of neck of right femur, nondisplaced spiral fracture of shaft of left femur (thighbone cracked by twisting force, creating a corkscrew pattern). During an interview on 05/12/26 at 9:08 A.M., the Administrator said CNA E utilized the mechanical lift by himself/herself when the resident became combative and the mechanical lift flipped over. The resident was sent to the hospital.During an interview on 05/12/26 at (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	9:10 A.M., The Director of Nursing (DON) said the resident was sent to the hospital because he/she suffered a bruise to the forehead.During an interview on 05/12/26 at 10:08 A.M., CNA E said he/she got the resident up and resident was in mechanical lift extended above his/her chair and he/she tried to brush the resident's hair. He/She said the resident started to flail his/her arms and mechanical lift tipped over. CNA E said he/she tried to stop the mechanical lift from tipping over but could not. CNA E said he/she did not utilize the break on the mechanical lift and did not have another staff member in the room to help him/her and should have. 3. Review of Resident #1's Quarterly Minimum Data Set (MDS), a federally mandated assessment, dated 02/20/26, showed staff assessed the resident as cognitively intact and dependent on staff to transfer to and from a bed to a chair (or wheelchair), turning and repositioning.Review of the resident's care plan, dated 01/15/25, showed staff assessed the resident had an activity of daily living (ADL) self-care performance deficit related to left side weakness and required two staff for transferring, turning and repositioning.Review of the facility report, dated 04/21/26, showed the Certified Nurse Aide (CNA) A documented he/she repositioned the resident by rolling him/her towards the wall, when he/she heard a pop. The resident immediately expressed pain, stating ow and reported his/her leg hurt.Review of the facility's Skilled Nursing Facility to Hospital Transfer Form, dated 04/23/26, showed the diagnosis for admission was pain in the left knee.Review of the resident's progress notes, dated 04/24/26, showed staff documented the nurse at the hospital reported the resident admitted for fractured femur.During an interview on 04/30/26 at 10:38 A.M., CNA A said during the repositioning of the resident, he/she heard a pop noise and the resident yelled out in pain. He/She said he/she knew he/she should have asked for assistance, but the other staff members were busy.During an interview on 04/30/26 at 10:49 A.M., LPN B said he/she did not recall if CNA A reported the incident to him/her because he/she was busy assisting a new admission. He/She said he/she did see the resident on 04/21/26 between 9:30 to 10:00 P.M. and he/she did complain about pain in his/her legs, but upon assessment, did not see any injuries. He/She said he/she did not contact the physician since the resident had a history of leg pain.4. Review of Resident #2's Quarterly MDS, dated [DATE], showed the resident dependent on staff to transfer from bed to a chair (or wheelchair).Review of resident's care plan, dated 04/09/26, showed staff assessed the resident had limited physical mobility related to Alzheimer's and total dependent on staff for locomotion.Observation on 04/30/26 at 12:00 P.M., showed CNA C entered the resident's room to provide care. He/She transferred the resident from the bed to the chair with a mechanical lift with a hospice employee. CNA C operated the mechanical lift while the hospice employee stood over by the resident's wheelchair. The resident swung in the air, without staff guidance, while being transferred from the bed to the chair.During an interview on 04/30/26 at 12:11 P.M., CNA C said he/she would open the legs, the other staff should be guiding the resident. He/She did see the resident swing in the air. He/She should have told him/her to guide the resident. CNA said the concern is the resident could fall if other staff do not hold onto the resident 5. During an interview on 04/30/26 at 10:49 A.M., Licensed Practical Nurse (LPN) B said two staff members are required when transferring a resident with a mechanical lift. He/She said the purpose for two staff was for one person to operate the lift and the other would guide the resident to safely transfer the resident.During an interview on 04/30/26 at 1:14 P.M., the administrator said there should be two staff members when transferring a resident with a mechanical lift. He/She said the concern with not using two staff members is the potential for residents to sustain injury.During an interview on 05/12/26 at 9:08 A.M., the Administrator said the expectation is two staff members should be present when using a mechanical lift to avoid injury. Complaint #2993245Incident #3001682