STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265538	A. Building B. Wing	11/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire Senior Living Roaring River	812 Old Exeter Road Cassville, MO 65625

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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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to ensure all resident representatives were notified of regarding changes in condition in a timely manner when staff failed to inform one resident's (Resident #1) representative of a decline in his/her wound until two days after the decline was documented. The facility census was 64. Review of the facility policy entitled Notification of Changes, dated 10/01/25, showed the following:-This policy is to ensure the facility promptly informs the resident, consults the resident's physician, and notifies, consistent with his/her authority, the resident's representative when there is a change requiring notification;-The facility must inform the resident, consult the resident's physician, and notify, consistent with his/her authority, the resident's representative when there is a change requiring notification;-Circumstances that require notification include accidents, significant changes in resident's physical, mental, or psychosocial condition, circumstances that require a need to alter treatment such as a new treatment or discontinuation of current treatment due to adverse consequences, acute condition, and exacerbation of a chronic condition. Review of the facility policy entitled Wound Treatment Management, undated treatment decisions will be based on etiology of the wound, characteristics of the wound, location of the wound, and the goals and preferences of the resident/representative. 1. Review of Resident #1 face sheet (a document that gives a resident's information at a quick glance) showed the following information:-admission date of 10/15/25;-Diagnoses included pressure ulcer (an area of the skin and tissue injured due to pressure on the skin for a long time) of sacral region (the triangular area at the base of your spine), age related physical debility (general weakness related to aging), dysphagia (difficulty swallowing), wedge compression fracture of the third vertebra (a type of fracture in the spine), and wedge compression fracture of the fifth vertebra;-Residents responsible party contact information listed. Review of the resident's admission Minimum Data Set (MDS - a federally mandated comprehensive assessment instrument completed by facility staff), dated 10/15/25, showed the following information:-The resident was cognitively impaired;-The resident required substantial/max assist for eating, toileting, showering, bathing, personal hygiene, rolling from side to side, and all transfers;-The resident used a manual wheelchair. Review of the resident's care plan, updated 10/31/25, showed the following:-The resident had a power of attorney because he/she was unable to make decisions for self;-The resident required help with bed mobility when fatigued;-The resident had a pressure injury to his/her coccyx (tailbone);-The resident often refused to reposition or turn to relieve pressure;-Staff should turn and reposition the resident every two hours and as needed. Review of the resident's Physician Orders, dated 10/15/25 to 11/07/25, showed an order, dated 10/16/25, for staff to cleanse wound to coccyx with hypochlorous acid (a disinfectant), apply skin prep (used to apply a protective film over skin that helps to prepare it for adhesives) to area cover with bordered dressing, and change dressing every three days for wound care.Review of the resident's nursing progress notes, dated 10/15/25 to 11/07/25, showed the following:-On 10/15/25, the Assistant Director of Nursing (ADON) documented a 1.4 centimeter (cm) by 0.5 cm by 0.1 cm, stage two pressure area (partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer) to the resident sacrum/coccyx;-On 10/29/25, the ADON documented a stage two pressure area to sacrum/coccyx area, dark pink with no open area;-On 11/01/25, the ADON documented a stage two pressure area to sacrum/coccyx area and resident refused treatment;-On 11/05/25, the ADON documented a 5.5 cm by 5 cm by 0.5 cm, stage four pressure area (full-thickness skin and tissue loss) to sacrum/coccyx area with necrotic (dead) tissue present. The wound has deteriorated. Staff notified physician with new orders received. (Staff did not document notification of the resident's representative of the change in the wound's condition or new orders received.) Review of the resident's Physician Orders, dated 10/15/25 to 11/07/25, showed an order, dated 11/07/25, for staff to cleanse wound to coccyx with hypochlorous acid, apply calcium alginate (highly absorbent dressing/substance) to wound bed, cover with bordered gauze, and change every day and as needed. Review of the resident's nursing progress notes dated 11/07/25, at 7:15 P.M., showed staff documented family present at bed side informed of wound to coccyx and plan for treatment. Family then went to resident's room. Fifteen minutes later family informed staff of request to send resident to emergency room for wound evaluation at 7:36 P.M., second family member arrived at bed side and requested resident transferred to emergency room. Staff notified the Administrator and ADON. Resident sent to emergency room at 7:46 P.M. During an interview on 11/13/25, at 11:00 A.M., the ADON said the following: -He/she was the wound care nurse for the facility and did the wound treatments along with the charge nurses;-He/she measured all wounds of residents who were not seen by the wound care