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	02/24/2026

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

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to provide care per standards of practice when staff failed to ensure weekly skin assessments and wound care was completed and documented for four residents (Resident #30, #49, #2, #6) with skin abrasions, including skin cancer, skin tears, and venous wounds. The facility census was 69. Review of the facility policy, dated 10/01/25, titled Wound Treatment Management, showed the following:-To promote wound healing of various types of wounds, it is the policy of this facility to provide evidence-based treatments in accordance with current standards of practice and physician orders;-Wound treatments will be provided in accordance with physician orders, including the cleansing method, type of dressing, and frequency of dressing change;-In the absence of treatment orders, the licensed nurse will notify physician to obtain treatment orders. This may be the treatment nurse, or the assigned licensed nurse in the absence of the treatment nurse;- Dressing changes may be provided outside the frequency parameters in certain situations:- Feces has seeped underneath the dressing;- The dressing has dislodged;-The dressing is soiled otherwise or is wet.-Dressings will be applied in accordance with manufacturer recommendations;-Treatment decisions will be based on etiology of the wound:-Pressure injuries will be differentiated from non-pressure ulcers, such as arterial, venous, diabetic, moisture or incontinence related skin damage;-Surgical, incidental (skin tear), atypical (Cancerous lesion);-Guidelines for dressing selection may be utilized in obtaining physician orders;-The guidelines are to be used to assist in treatment decision making;-Due to unique needs and situations of individuals, the guidelines may not be appropriate for use in all circumstances;-The facility will follow specific physician orders for providing wound care;- The effectiveness of treatments will be monitored through ongoing assessment of the wound;-Treatments will be documented on the Treatment Administration Record or in the electronic health record. Review of the facility policy, dated 10/01/25, titled Documentation of Wound Treatments, showed the following:- The facility completes accurate documentation of wound assessments and treatments, including response to treatment, change in condition, and changes in treatment;-The facility is in partnership with a wound company that makes weekly and as needed visits;- Wound assessments are documented upon admission, weekly, and as needed if the resident or wound condition deteriorates; - The following elements are documented as part of a complete wound assessment:a. Type of wound (pressure injury, surgical, etc.) and anatomical locationb. Stage of the wound, if pressure injury (stage I, 2, 3, 4, deep tissue pressure injury, unstageable pressure injury) or the degree of skin loss if non-pressure (partial or full thickness);-Measurements: height, width, depth, undermining, tunneling;-Description of wound characteristics;- Color of the wound bed;- Type of tissue in the wound bed (i.e., granulation, slough, eschar, epithelium);- Condition of the peri-wound skin (dry, intact, cracked, warm, inflamed, macerated);-Presence, amount, and characteristics of wound drainage/exudate;-Presence or absence of odor;-Presence or absence of pain;-Wound treatments are documented at the time of each (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	treatment;-If no treatment is due, an indication on the status of the dressing shall be documented each shift (i.e., clean, dry, intact);-Additional documentation shall include, but is not limited to:-Date and time of wound management treatments;-Weekly progress towards healing and effectiveness of current intervention;-Any treatment for pain, if present;-Modifications of treatments or interventions;-Notifications to physician and/or responsible party regarding wound or treatment. Review of the facility provided undated schedule, titled Weekly Schedule for Vital Signs and Skin Assessments, showed the following:-A binder at the nursing desk with this schedule;-6 AM TO 6 PM Halls A&B - Sunday 101A, 101B, Monday 103A, 103B, 104A, Tuesday 106A, 106B, 107A, Wednesday 109A, 109B, 110A, Thursday 114A, 114B, 115A, 115B, Friday call families regarding new orders, Saturday 120A, 120B, 121A;-6 PM TO 6 AM Halls A&B - Sunday 102A, 102B, Monday 104B, 105A, 105B, Tuesday 107B, 108A, 108B, Wednesday 110B, 111A, 111B, Thursday 116A, 116B, 117A, 117B, Friday 118A, 118B, 119A, 119B, Saturday 121B, 122A, 122B;-6 AM TO 6 PM Halls C,E,&F - Sunday 124, 125, 126, 127, Monday 129B, 130A, 130B, Tuesday 132B, 133A, 133B, Wednesday 135B, 136A, 136B, Thursday 138B, 139A, 139B, 140A, Friday call families with new orders, Saturday 144B, 145A, 145B;-6 PM TO 6 AM Halls C,E,&F - Sunday 128A, 128B, 129A, Monday 131A, 131B, 132A, Tuesday 134A, 134B, 135A, Wednesday 137A, 137B, 138A, Thursday 140B, 141A, 141B, 142A, Friday 142B, 143A, 143B, 144A, Saturday 146A, 146B, 147A, 147B. 1. Review of Resident #49's face sheet showed the following: -admitted [DATE];-Diagnoses included: Diffuse traumatic brain injury (widespread brain damage occurs when the brain moves rapidly in the skull) with loss of consciousness (temporary prolonged state of unresponsiveness), peripheral vascular disease (slow, progressive circulation disorder involving narrowing, blockage, or spasms in blood vessels outside the heart and brain, most commonly affecting the legs), dermatitis (skin becomes red, swollen, and sore, sometimes with small blisters, resulting from direct irritation to the skin). Review of the resident's annual Minimum Data Set (MDS, a federally mandated comprehensive assessment instrument, completed by facility staff), dated 12/26/25, showed the following:-Severe cognitive impairment;-Use of wheelchair;-Resident at risk of developing pressure ulcers or injuries;-No open wound were present;-Substantial to maximal assistance for toileting hygiene, showering, dressing, personal hygiene. Review of the resident's care plan, last reviewed 12/26/25, showed the following:-Resident had the potential for skin impairment related to fragile skin;-Staff should follow facility protocols for treatment of injury. Observation on 02/18/26, at 2:00 P.M., showed resident in wheelchair in room, bilateral lower legs with undated wraps. Resident was not able to verbalize if bandages were changed. Review of the Treatment Administration Record (TAR), for February 2026, showed the following:-An order with a start date of 02/12/26 and a date to discontinue of 02/19/26, shows to apply a light a two-layer compression wrap to left lower extremity twice per week (Monday and Thursday) in the afternoon for wound care;-Staff did not document treatment as completed on 02/12/26, 02/16/26, or 02/19/26;-An order start date of 02/19/26 and a date to discontinue of 02/23/26, shows to cleanse lower extremity with wound cleanser, apply a light two-layer compression wrap to left lower extremity, change twice per week;-Staff did not document as completed on 02/19/26, 02/20/26, 02/21/26, 02/22/26, or 02/23/26 (5 out of 5 days not documented). Review of the nursing progress notes, for February 2026, showed the following:-No documentation related to wound care not being provided or refused by resident;-No weekly skin assessment for noted. Review of the Assistant Director of Nursing (ADON) wound measurements list, dated 02/12/26, showed no measurements documented for the resident. Review of the Wound Physician progress notes, dated 02/19/26, showed the following:-Bilateral stasis (state of inactivity) dermatitis. Recommended elevating the legs and to cleanse the wound with wound cleanser at the time of dressing changes;-Recommended arterial and venous doppler testing. Observation on 02/19/26, at 5:32 P.M., (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	showed the following:-Wound Physician and DON entered resident room;-DON removed undated wraps on bilateral lower legs;-Left lower leg with small areas of redness. Skin intact;-Right lower leg red with swelling and no open areas;-Recommended arterial and venous dopplers (non-invasive, painless ultrasound test evaluates blood flow through arteries and veins) and continue wrap on left side only. 2. Review of Resident #2's face sheet showed the following: -admitted on [DATE];-Diagnoses included: Congestive Heart Failure (CHF), or heart failure, (a condition in which the heart can't pump enough blood to the body's other organs), infection of right lower extremity amputation stump (remaining portion of an extremity after surgical removal), open wound right lower leg. Review of Weekly skin observation, dated 02/02/26, showed the following:-Existing skin issue - scattered bruising to bilateral upper extremity, redness to buttock, wound vac (medical device that uses suction to speed the healing of wounds) in place to right above the knee amputation stump, ulcers to left lower extremity, shin, scabs to left toes, fingers, inside of left foot and ankle. Review of the resident's care plan, date initiated 02/03/26 , showed the following:-Resident at risk for impaired skin integrity related to mobility issues;-Nursing to do a weekly skin assessment and report any issues to the physician for treatment;-Resident had wounds on bilateral lower extremities;-Staff should complete a weekly skin audit by licensed nurse;-Staff should provide wound treatment as ordered. Review of the wound care provider note, dated 02/05/26, showed the following:-Skin tear left lateral calf, first evaluation, (length x width x depth) 4.2 x 2.1 x 0.1 centimeter (cm), present on admission. Review of the resident's admission MDS, dated [DATE], showed the following:-Cognitively intact;-Use of wheelchair;-Resident at risk of developing pressure ulcers or injuries;-Resident had open lesion, surgical wound, a skin tear on admission;-Dependent on staff for toileting hygiene, showering;-Substantial to maximal assistance for dressing;-Partial to moderate assistance for personal hygiene. Review of the Treatment Administration Record, for the Month of February 2026, showed the following:-An order with a start date of 02/07/26 and date to discontinue of 02/19/26, showed to change the dressing to left lower extremity. Clean with wound cleanser, place xeroform (sterile, non-adhering petroleum based, fine-mesh gauze dressing used as primary contact layer) on lesions, ABD (thick, highly absorbent, sterile, non-woven pad used to manage large wounds with moderate to heavy drainage, often acting as a secondary dressing to cushion and protect) over and wrap with kerlix (cotton gauze bandage rolls used for wound dressing) one time a day for wound care;-Staff did not document care as completed on 02/09/26, 02/12/26, 02/13/26, or 02/15/26 (4 out of 12 days not documented);-An order start date 02/14/26 and discontinue date 02/16/26, showed to wash incision to right stump with soap and water. Maintain dry dressing to right lower stump with incision covered by xeroform and ABD. Change dressing daily for surgical wound; Acute and chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease, end stage renal disease-Staff did not document care as completed on 02/15/26 (1 out of 3 days not documented). Review of ADON wound measurements list, dated 02/12/26, showed the following:-Left calf wound 4.0 by 2.0 by 0.1 cm - improved. Observation on 02/19/26, at 5:20 P.M., showed the following:-Wound Physician and DON entered the resident's room;-Removed undated bandage from the surgical wound on the right stump. To continue the surgeon's orders;-Removed undated bandage from left lower leg. The wound had improved and a new order started for foam with border to be applied three times per week and as needed. 3. Review of Resident #6's face sheet showed the following: -admitted [DATE];-Diagnoses included: Acute and chronic respiratory failure with hypoxia (condition that results in the inability to effectively exchange carbon dioxide and oxygen, and causes chronically low oxygen levels or chronically high carbon dioxide levels), chronic obstructive pulmonary disease (COPD - group of lung diseases that block airflow and make it difficult to breathe), end stage renal disease (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(final, irreversible stage of disease where kidney function drops to less than 15% of normal). Review of the resident's quarterly MDS, dated [DATE], showed the following:-Cognitively intact;-Use of wheelchair;-Resident is at risk of developing pressure ulcers or injuries;-Resident had no open wounds;-Substantial to maximal assistance for toileting hygiene;-Partial to moderate assistance for showering, dressing, personal hygiene; Review of the Treatment Administration Record (TAR), for the Month of February 2026, showed the following:-An order with a start date of 02/03/26 and a discontinue date of 02/19/26, showed to cleanse the left lower extremity posterior wound with wound cleanser, apply xeroform, cover with super absorbent dressing, change three times per week (Tuesday, Thursday, and Saturday) and as needed if saturated, soiled or dislodged;-Staff did not document as completed on 02/03/26, 02/05/26, 02/10/26, or 02/12/26 (4 out 8 days not documented);-An order start date of 02/03/26 and a discontinue date of 02/19/26, showed to cleanse the right lower extremity with wound cleanser, apply fibracol (soft, absorbent, non-adherent dressing designed to maintain moist environment that promotes new tissue and rapid healing) and cover with super absorbent dressing, change three times per week (Tuesday, Thursday and Saturday) and as needed if saturated, soiled or dislodged;-Staff did not document as completed on 02/03/26, 02/05/26, 02/10/26, or 02/12/26 (4 out of 8 days not documented);-An order start date 02/20/26, showed to cleanse the right lower extremity wound with wound cleanser, apply skin prep to right lower leg daily and as needed if saturated, soiled for wound care;-Staff did not document as completed on 02/20/26, 02/21/26, or 02/22/26 (3 out of 4 days not documented). Review of the nursing progress notes, for February 2026, showed the following: -No documentation related to wound care not being provided or refused by the resident;-No weekly skin assessment noted. Review of the wound physician progress notes, dated 02/05/26, showed the following:-Venous wound of the right leg full thickness, wound size 1 x 6.2 x 0.1cm, no signs of infection;-Venous wound of the left calf full thickness, wound size 1.4 x 2.1 x 0.2cm, no signs of infection. Review of the ADON wound measurements list, dated 02/12/26, showed the resident was in the hospital.Observation on 02/18/26, at 1:00 P.M., showed the resident in a recliner in his/her room under droplet precautions. The resident's bilateral lower legs were covered by a white gauze wrap. No dates were observed on the wrap. Review of the wound physician progress notes, dated 02/19/26, showed the following:-Venous wound of the right leg full thickness, wound size length 1cm by width 5.1 cm, depth unmeasurable due to presence of dried fibrinous exudate, no signs of infection;-Venous wound of the left calf full thickness, wound size 3.1 x 0.9 x 0.2cm, no signs of infection. Observation on 02/19/26, at 5:54 P.M., showed the following:-Wound Physician and DON entered the resident's room;-DON removed undated dressing from bilateral lower legs;-Right leg with dried scabbed areas;-Left leg with area of 3.4 x 1.8 x 0.2 cm with some clear drainage and redness;-Wound physician recommended skin prep to right leg and continue current treatment plan for left leg. 4. Review of Resident #30's face sheet showed the following:-admitted [DATE];-Diagnoses include COPD, CHF, atrioventricular block first degree (mild conduction delay in the heart), cardiac arrhythmia (abnormal heart rhythm), atrial fibrillation (fast and irregular heart rhythm), chronic kidney disease, and nonrheumatic mitral insufficiency (condition where the mitral valve fails to close properly causing blood flow backward into the left atrium). Review of the resident's care plan, last revised 11/12/25, showed the following:-Resident is at risk for impaired skin integrity related to age and mobility issues;-Resident will have clean and intact skin through next review date;-Report an area of concern related to skin to the nurse;-Nursing is to do a weekly skin assessment and report any issues to my physician for treatment.Review of the resident's current physician order showed the following:An order dated 02/13/26, showed to cleanse the wound/stitches with an antibacterial soap and water using a Q-Tip. Gently remove any crust or (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	scab from the wound working in between the sutures. Apply a thick coat of Bacitracin ointment to the wound cover with nonadherent dressing and secure with tape for two weeks every evening shift for wound care. Review of the resident's February 2026 Treatment Administration Record (TAR) showed the following: -An order dated 02/13/26, cleanse the wound/stitches with an antibacterial soap and water using a Q-Tip. Gently remove any crust or scab from the wound working in between the sutures. Apply a thick coat of Bacitracin ointment to the wound cover with nonadherent dressing and secure with tape for two weeks every evening shift for wound care. -Staff documented administering the above treatment on 02/15/26 and 02/18/26;-Staff did not document administering the above treatment on 02/13/26, 02/14/26, 02/16/26, and 02/17/26.An observation and interview with the resident on 02/17/26, at 1:55 P.M., showed the following:-The resident said he/she had skin cancer removed from the face recently and is concerned because staff should be treating and bandaging the area daily. The resident did not have a bandage on her face. Review of the resident's quarterly MDS dated [DATE], showed the following:-Moderate cognitive impairment;-Resident has open lesions requiring non-surgical dressing and application of ointments/medication;-Dependent on staff for transfers, bed mobility, and showers. 5. During an interview on 02/18/26, at 11:20 A.M., LPN A said residents have complained that wound care was not completed at times. The nurses are to complete wound care according to the physician orders. On Thursdays the ADON rounded with the Wound Physician and completed care. He/she said some days was difficult to get all of the resident care completed. 6. During an interview on 02/19/26, at 9:35 AM, RN B said the nurses were to complete the weekly wound assessments. There was a binder at the nursing station that shows which room was due for the assessment. The TAR shows when the wound care is due. The ADON follows with the wound care physician and entered any new orders into the resident's chart. He/she said that if he/she was unable to get all work done for the day he/she would pass it along to the next shift. The TAR would only show the order for the shift it was due. The treatment would show as incomplete for the next shift. He/she said that staff should chart when wound care was done, if not charted it was not done. He/she would not expect to see holes in the TAR. unless there is a note or it is passed along in report. If a resident refused treatment there is a code to document that and make a progress note. He/she said if it was a really busy day he/she would get the treatments done and try to take time to chart later. 7. During an interview on 02/19/26, at 10:39 A.M., the ADON said he/she monitors wound tracking. The wound physician comes once per week. The admission nurse should start the skin assessment. There is a weekly schedule in a binder at the nurse's desk. He/she will do wound care if working on the floor or if the scheduled staff were not able to get the wound care done. He/she said that the wound dressing should be dated, sometimes staff forget to date it but it should also be documented on the TAR. There should not be blank spots on the TAR. If it was not charted, it was not done. Some days wound care was not charted but he/she knew it was done. Sometimes a resident might refuse wound care, so he/she would not document and then would try to go back later and see if could complete the care. Staff should let the other staff know when work was not completed. He/she said that he/she was working on the floor most days that he/she worked. He/she had been completing most of the wound care daily until October when new corporation took over and then the floor nurses were scheduled to do the wound care. The wound care physician was not here on the week of 02/12/26, so the ADON completed some measurements of wounds but did not get them all done. 8. During an interview on 02/19/26, at 11:15 A.M., the Medical Director said that staff should follow physician orders and that if it was not documented he would assume it was not done. He stated it was helpful when staff date the dressing in case the documentation was forgotten. There was a risk of wounds not healing and becoming infected if care not completed. 9. During an interview on (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to provide care per standards of practice when staff failed to ensure weekly skin assessments and wound assessments were completed and documented for five residents (Resident #40, #53, #11, #61, #25) with pressure ulcers (localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device). The facility census was 69. Review of the facility policy, dated 10/01/25, titled Wound Treatment Management, showed the following:-To promote wound healing of various types of wounds, it is the policy of this facility to provide evidence-based treatments in accordance with current standards of practice and physician orders;-Wound treatments will be provided in accordance with physician orders, including the cleansing method, type of dressing, and frequency of dressing change;-In the absence of treatment orders, the licensed nurse will notify physician to obtain treatment orders. This may be the treatment nurse, or the assigned licensed nurse in the absence of the treatment nurse;- Dressing changes may be provided outside the frequency parameters in certain situations:- Feces has seeped underneath the dressing;- The dressing has dislodged;-The dressing is soiled otherwise or is wet.-Dressings will be applied in accordance with manufacturer recommendations;-Treatment decisions will be based on etiology of the wound:-Pressure injuries will be differentiated from non-pressure ulcers, such as arterial, venous, diabetic, moisture or incontinence related skin damage;-Guidelines for dressing selection may be utilized in obtaining physician orders;-The guidelines are to be used to assist in treatment decision making;-Due to unique needs and situations of individuals, the guidelines may not be appropriate for use in all circumstances;-The facility will follow specific physician orders for providing wound care;- The effectiveness of treatments will be monitored through ongoing assessment of the wound;-Treatments will be documented on the Treatment Administration Record or in the electronic health record. Review of the facility policy, dated 10/01/25, titled Documentation of Wound Treatments, showed the following:- The facility completes accurate documentation of wound assessments and treatments, including response to treatment, change in condition, and changes in treatment;-The facility is in partnership with a wound company that makes weekly and as needed visits;- Wound assessments are documented upon admission, weekly, and as needed if the resident or wound condition deteriorates; - The following elements are documented as part of a complete wound assessment:a. Type of wound (pressure injury, surgical, etc.) and anatomical locationb. Stage of the wound, if pressure injury (stage l, 2, 3, 4, deep tissue pressure injury, unstageable pressure injury) or the degree of skin loss if non-pressure (partial or full thickness);-Measurements: height, width, depth, undermining, tunneling;-Description of wound characteristics;- Color of the wound bed;- Type of tissue in the wound bed (i.e., granulation, slough, eschar, epithelium);- Condition of the peri-wound skin (dry, intact, cracked, warm, inflamed, macerated);-Presence, amount, and characteristics of wound drainage/exudate;-Presence or absence of odor;-Presence or absence of pain;-Wound treatments are documented at the time of each treatment;-If no treatment is due, an indication on the status of the dressing shall be documented each shift (i.e., clean, dry, intact);-Additional documentation shall include, but is not limited to:-Date and time of wound management treatments;-Weekly progress towards healing and effectiveness of current intervention;-Any treatment for pain, if present;-Modifications of treatments or interventions;-Notifications to physician and/or responsible party regarding wound or treatment. Review of the facility provided undated schedule, titled Weekly Schedule for Vital Signs and Skin Assessments, showed the following:-A binder at the nursing desk with this schedule;-6 AM TO 6 PM Halls A&B - Sunday 101A, 101B, Monday 103A, 103B, 104A, Tuesday 106A, 106B, 107A, Wednesday 109A, 109B, 110A, (continued on next page)

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Thursday 114A, 114B, 115A, 115B, Friday call families regarding new orders, Saturday 120A, 120B, 121A;-6 PM TO 6 AM Halls A&B - Sunday 102A, 102B, Monday 104B, 105A, 105B, Tuesday 107B, 108A, 108B, Wednesday 110B, 111A, 111B, Thursday 116A, 116B, 117A, 117B, Friday 118A, 118B, 119A, 119B, Saturday 121B, 122A, 122B;-6 AM TO 6 PM Halls C,E,&F - Sunday 124, 125, 126, 127, Monday 129B, 130A, 130B, Tuesday 132B, 133A, 133B, Wednesday 135B, 136A, 136B, Thursday 138B, 139A, 139B, 140A, Friday call families with new orders, Saturday 144B, 145A, 145B;-6 PM TO 6 AM Halls C,E,&F - Sunday 128A, 128B, 129A, Monday 131A, 131B, 132A, Tuesday 134A, 134B, 135A, Wednesday 137A, 137B, 138A, Thursday 140B, 141A, 141B, 142A, Friday 142B, 143A, 143B, 144A, Saturday 146A, 146B, 147A, 147B. 1. Review of Resident #40's face sheet (brief information sheet about the resident) showed the following: -admitted [DATE];-Diagnoses included: type 2 diabetes mellitus (chronic condition that affects the way the body processes blood sugar (glucose)) with diabetic neuropathy (nerve damage caused by long-term high blood sugars), local infection of the skin and subcutaneous skin (under the layers of skin), pressure ulcer of sacral region stage 4 (severe, full-thickness wound extending through the skin to expose muscle, tendon, or bone), pressure ulcer of other site unstageable, osteomyelitis (serious infection of the bone marrow and bone tissue) of vertebra (one of the 33 individual, irregular bones that stack to form the spinal column), sacral (large, inverted triangle-shaped bone located at the very base of the spine, situated between the two hip bones) and sacrococcygeal region (referring to the region of the sacrum and the coccyx (the tailbone)), acquired absence (surgical removal) of left leg below knee. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated comprehensive assessment completed by facility staff), dated 02/14/26, showed the following:-Cognitively intact;-Use of wheelchair;-Substantial to maximal assistance for personal hygiene, dressing;-Dependent on staff for showering, toileting hygiene;-Resident has pressure ulcer or injury;-Resident at risk for developing pressure ulcers or injuries;-Resident has two stage 3 pressure ulcers;-One stage 3 pressure was present on admission. Review of the resident's care plan, last reviewed 01/03/26, showed the following:-Resident had a pressure ulcer on coccyx and right ischial tuberosity (large, rounded bony protrusion located in the lower pelvis situated in the buttocks, support the body's weight while sitting);-Staff should assess and record wound healing, measure length, width, depth where possible (staff did not care plan how often); -Staff should assess and document status of wound perimeter, wound bed and healing progress (staff did not care plan how often);-Staff should perform all treatment per physician's orders;-If the dressing comes off or is soiled, staff should notify the wound care nurse for timely wound care. Review of the Treatment Administration Record (TAR), for the Month of January 2026, showed the following:-An order with a start date of 11/15/25 and a discontinue date of 01/13/26, showed to cleanse wound to coccyx with hypochlorous acid, apply calcium alginate to wound bed, cover with self-adhesive super absorbent dressing, change daily and as needed if soiled or missing dressing for wound care;-Staff did not document care completed on 01/01/26, 01/02/26, 01/03/26, 01/05/26, 01/06/26, 01/08/26, 01/09/26, 01/10/26, 01/11/26, 01/12/26, or 01/13/26 (11 out of 13 days not documented);-An order with a start date of 01/03/26 and a discontinue date of 01/13/26, shows to remove old dressing with adhesive remover from the right sacrum wound, cleanse the wound with vashe (wound care solution to cleanse, irrigate, moisten acute and chronic wounds), dry, apply skin prep (fast-drying, liquid film-forming dressing applied to intact skin around a wound to form a breathable, transparent, and protective barrier) to peri-wound (skin immediately surrounding a wound). Pack the wound with vashe soaked rolled gauze ensuring tunneling at 11 o'clock is packed. Cover with an ABD then Mextra (four-layer non-adhesive dressing). Secure with medipore tape (surgical tape with gentle adhesion for fragile skin) every day for wound care;-Staff did not document care completed on (continued on next page)

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	265538	A. Building B. Wing	02/24/2026

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	01/03/26, 01/05/26, 01/06/26, 01/08/26, 01/09/26, 01/10/26, 01/11/26, 01/12/26, or 01/13/26 (9 out of 11 days not documented);-An order start date 01/15/26, discontinue date 02/19/26, apply hydrocolloid paste (special wound dressing used for mild draining wounds) for once daily to scrotum for wound care;-Staff did not document care completed on 01/16/26, 01/17/26, 01/18/26, 01/20/26, 01/21/26, 01/22/26, 01/23/26, 01/24/26, 01/25/26, 01/26/26, 01/28/26, 01/29/26, 01/30/26 (13 out of 17 days not documented);-An order with a start date of 01/13/26, showed to cleanse the wound to the coccyx with wound cleanser, apply calcium alginate with silver to wound bed, cover with superabsorbent gelling fiber pad, change daily and as needed if saturated, soiled, or dislodged for wound care; -Staff did not document care completed on 01/14/26, 01/16/26, 01/17/26, 01/18/26, 01/20/26, 01/21/26, 01/22/26, 01/23/26, 01/24/26, 01/25/26, 01/26/26, 01/28/26, 01/29/26, or 01/30/26 (14 out of 19 days not documented);-An order with a start date of 01/13/26, showed to cleanse the wound to the right ischium (one of pelvic bones, referred to as sit bone in the buttock) with wound cleanser, apply calcium alginate (highly absorbent, antimicrobial primary wound dressing made from seaweed-derived fibers) with silver (to help with infected or chronic wound healing) to wound bed, cover with ABD pad (thick, sterile, and highly absorbent medical dressing designed to cover and protect large, heavily draining wounds) and secure with retention tape. Change daily and as needed if saturated, soiled, or dislodged for wound care; -Staff did not document care completed on 01/14/26, 01/16/26, 01/17/26, 01/18/26, 01/20/26, 01/21/26, 01/22/26, 01/23/26, 01/24/26, 01/25/26, 01/26/26, 01/28/26, 01/29/26, or 01/30/26 (14 out of 19 days not documented);-An order with a start date of 01/23/26, showed to cleanse the wound to the right stump with wound cleanser, apply calcium with silver to wound bed, cover with bordered gauze, change daily and as needed for saturated, soiled or dislodged dressing for wound care;-Staff did not document care completed on 01/23/26, 01/24/26, 01/25/26, 01/26/26, 01/28/26, 01/29/26, or 01/30/26 (7 out of 9 days not documented). Review of the Treatment Administration Record, for February 2026, showed the following:-An order with a start date of 01/15/26 and a discontinue date of 02/19/26, showed to apply hydrocolloid paste once daily to scrotum for wound care;-Staff did not document care completed on 02/01/26, 02/03/26, 02/04/26, 02/05/26, 02/06/26, 02/07/26, 02/09/26, 02/10/26, 02/12/26, 02/13/26, or 02/15/26 (11 out of 19 days not documented);-An order with a start date of 01/13/26, showed to cleanse the wound to the coccyx with wound cleanser, apply calcium alginate with silver to wound bed, cover with superabsorbent gelling fiber pad. Change daily and as needed, if saturated, soiled, or dislodged for wound care; -Staff did not document care completed on 02/01/26, 02/03/26, 02/04/26, 02/05/26, 02/06/26, 02/07/26, 02/09/26, 02/10/26, 02/12/26, 02/13/26, 02/15/26, or 02/23/26 (12 out of 23 days not documented);-An order with a start date of 01/13/26, showed to cleanse the wound to the right ischium with wound cleanser, apply calcium alginate with silver to wound bed, cover with ABD pad and secure with retention tape. Change daily and as needed if saturated, soiled, or dislodged for wound care; -Staff did not document care completed on 02/01/26, 02/03/26, 02/04/26, 02/05/26, 02/06/26, 02/07/26, 02/09/26, 02/10/26, 02/12/26, 02/13/26, 02/15/26, or 02/23/26 (12 out of 23 days not documented);-An order with a start date of 01/23/26, showed to cleanse the wound to the right stump with wound cleanser, apply calcium with silver to wound bed, cover with bordered gauze. Change daily and as needed for saturated, soiled or dislodged dressing for wound care;-Staff did not document care completed on 02/01/26, 02/03/26, 02/04/26, 02/05/26, 02/06/26, 02/07/26, 02/09/26, 02/10/26, 02/12/26, 02/13/26, 02/15/26, or 02/23/26 (12 out of 23 days not documented). Review of the wound physician progress notes, dated 02/05/26, showed the following:-Site one - stage 3 pressure wound of right ischium full thickness, 10.5 x 6.1 x 1.2 (length x width x depth), improved evidenced by decreased depth;-Site two - stage 3 pressure wound sacrum full thickness, 1.2 x 0.8 x (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1.3 cm, improved evidenced by decreased surface area;-Site three - non-pressure wound of the right distal stump full thickness, 3.5 x 3.1 x 0.1 cm, not at goal due to need more time;-Site four - non-pressure wound of the left scrotum partial thickness, 1.2 x 0.6 x 0.1 cm, improved evidenced by decreased surface area. Review of the nursing progress notes, for February 2026, showed the following:-No documentation related to wound care not being provided or refused by resident. Review of ADON wound measurements list, dated 02/12/26, showed the following:-Right ischium 10.3 x 6.1 x 1.1, improved;-Sacrum 1.1 x 0.5 x 1.2, improved;-Right stump 3.6 x 3.1 x 0.1, decline slough;-Scrotum 1.2 x 0.6 x 0.1, no change. Review of the nursing weekly skin observation, dated 02/13/26, showed no new skin concerns, see wound assessments for existing skin issues and accurate measurements. Review of the wound physician progress notes, dated 02/19/26, showed the following:-Site one - stage 3 pressure wound of right ischium full thickness, 7.2 x 6.3 x 1.1 cm, improved evidenced by decreased depth;-Site two - stage 3 pressure wound sacrum full thickness, 1.3 x 1 x 0.2 cm, improved evidenced by decreased depth;-Site three - non-pressure wound of right distal stump thickness, 3 x 3.1 x 0.1 cm improved evidenced by decreased necrotic tissue and decreased surface area;-Site four - non-pressure wound of left scrotum - resolved on 02/19/26. Observation and interview on 02/18/26, at 2:55 P.M., showed the following:-RN B entered the resident's room with wound care supplies, applied a gown, and completed hand hygiene and applied gloves;-He/She pulled the resident's pant leg up over the right stump and said, that is the bandage I put on Saturday. The bandage was undated. The nurse removed the bandage and sprayed wound cleanser on gauze and cleaned an area on the end of the right stump;-The area was open and beefy red with some pink drainage. Size of the area was approximately 3 x 3 cm;-The nurse removed his/her gloves and completed hand hygiene and applied gloves;-Sprayed wound cleanser on the wound and cleaned with gauze; -Prepared calcium alginate to size of the wound bed and skin prepped the skin around the wound;-Calcium alginate and the border dressing were applied and dated 2/18/26;-The nurse assisted the resident to roll to the left side, opened his/her brief, and removed bandages on the coccyx and the right buttock;-The bandages were undated;-The coccyx area was open with no drainage;-Observation showed the right ischium area to have slight drainage and the nurse stated there was a slight odor;-The wounds were cleansed with wound cleanser;-RN B removed his/her gloves, completed hand hygiene, and applied gloves;-Skin prep was applied around the wounds and calcium alginate was prepared to size and applied to the coccyx;-Blue super absorbent border dressing was applied; -RN B applied calcium alginate to the right ischium, applied gelling fiber and an ABD pad, taped the bandage. removed gloves, removed gown, and completed hand hygiene;-The nurse did not date the two bandages on the resident's buttocks area. During an interview on 02/18/26, at 3:46 P.M., RN B said the bandage appeared to be the same as when he/she completed on Saturday (02/14/26). He/She stated there were times that the wound care did not get completed and dressing changes were not charted as completed. He/she stated there were times that there was other work that keeps him/her from getting to the wound care during the shift. Observation on 02/19/26, at 4:35 P.M., showed the following:-The wound care provider and the DON entered the resident's room and donned a gown and gloves;-The bandage, dated 02/18/26, was removed from the right stump and observation showed an area of approximately 3 by 3 cm with mild red drainage on bandage; -DON completed the wound care and did not date the bandage, saying he/she would return to date it;-The resident was assisted to roll to his/her left side;-The resident had an undated bandage on his/her coccyx and an undated bandage on the right ischial area;-DON removed the bandages and the wound care provider measured the wounds and stated the ischium area was about the same, maybe better. He/She said the coccyx area was healing well;-The wound care provider recommended staff continue same treatment;-DON completed wound care and stated would return to (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	date bandages. 2. Review of Resident #53's face sheet showed the following: -admitted [DATE];-Diagnoses included: Arnold Chiari Syndrome (structural defect where the lower part of the brain pushes down through the base of the skull into the top of the spinal canal) with spina bifida (congenital birth defect where the spinal column does not close completely during fetal development, often leaving the spinal cord and nerves exposed or damaged), paraplegia (impairment or loss of motor and sensory function in the lower half of the body), pressure ulcer of sacral region stage 4, pressure ulcer of buttock unspecified stage, osteomyelitis (serious, often bacterial, infection of the bone that causes inflammation, severe pain, swelling, and warmth in the affected area) of vertebra (one of the 33 bones that stack to form the spine) and lumbar (low back) region. Review of the resident's annual MDS, dated [DATE], showed the following:-Cognitively intact;-Use of wheelchair;-Substantial to maximal assistance for toileting hygiene, showering;-Partial to moderate assistance for personal hygiene, dressing;-Resident at risk for developing pressure ulcers or injuries;-Resident two stage 4 pressure ulcers that were present on admission. Review of the resident's care plan, last reviewed 12/22/25, showed the following:-Resident had a pressure injury to the ischium and sacrum, the skin was fragile;-The nurse should perform weekly skin assessments;-Wounds followed by wound care provider;-Staff should change dressing as ordered when they are scheduled and as needed soiling and saturation;-Staff should measure and document wound progress at least once per week. Review of the Treatment Administration Record, for the Month of January 2026, showed the following:-An order with a start date of 12/12/25 and a discontinue date of 02/09/26, showed to cleanse the sacral wound with wound cleanser, apply xeroform to wound bed, cover with ABD pad and secure with tape. Change daily and as needed, every evening shift for wound care;-Staff did not document care as completed on 01/03/26, 01/11/26, 01/17/26, 01/23/26, 01/25/26, or 01/29/26, 01/31/26 (7 of 31 days not documented);-An order with a start date of 12/12/25 with a discontinue date of 02/09/26, showed to cleanse the wound to the left ischium with wound cleanser, apply xeroform to wound bed, cover with ABD pad and secure with tape. Change daily and as needed every evening shift for wound care;-Staff did not document care as completed on 01/03/26, 01/11/26, 01/17/26, 01/23/26, 01/25/26, or 01/29/26, 01/31/26 (7 of 31 days not documented). Review of the Treatment Administration Record, for the Month of February 2026, showed the following:-An order start date 12/12/25, discontinue 02/09/26, cleanse sacral wound with wound cleanser, apply xeroform to wound bed, cover with ABD pad and secure with tape, change daily and as needed every evening shift for wound care;-Staff did not document care as completed on 02/06/26, 02/08/26 (2 of 8 days not documented);- An order with a start date of 12/12/25 and a discontinue date of 02/09/26, showed to cleanse the wound to the left ischium with wound cleanser, apply xeroform to wound bed, cover with ABD pad and secure with tape. Change daily and as needed every evening shift for wound care;-Staff did not document care as completed on 02/06/26 or 02/08/26 (2 of 8 days not documented);- An order with a start date of 02/09/26, showed to cleanse the sacral wound with wound cleanser, apply xeroform to wound bed, cover with ABD pad and secure with tape. Change daily and as needed, in the afternoon, for wound care;-Staff did not document care as completed on 02/09/26, 02/10/26, 02/15/26, 02/17/26, 02/18/26, 02/19/26, 02/20/26, 02/21/26, 02/22/26, 02/23/26, 02/24/26, 02/25/26, 02/26/26, 02/27/26, or 02/28/26 (15 out of 20 days not documented);- An order with a start date of 02/09/26, showed to cleanse the wound to the left ischium with wound cleanser, apply xeroform to wound bed, cover with ABD pad and secure with tape. Change daily and as needed in the afternoon for wound care;-Staff did not document care as completed on 02/09/26, 02/10/26, 02/15/26, 02/17/26, 02/18/26, 02/19/26, 02/20/26, 02/21/26, 02/22/26, 02/23/26, 02/24/26, 02/25/26, 02/26/26, 02/27/26, or 02/28/26 (15 out of 20 days not documented). Review of the nursing progress notes, for February 2026, showed the (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	following:-No documentation related to wound care not being provided or refused by resident. Review of the wound physician progress notes, dated 02/05/26, showed the following:-Site one - stage 4 pressure wound sacrum full thickness, 10.5 x 5.5 x 2 cm, improved evidenced by decreased depth, decreased surface area, decreased undermining;-Site two - stage 4 pressure wound of the left ischium full thickness, 1.9 x 0.3 x 0.3 cm, improved evidenced by decreased depth, decreased surface area. Review of weekly wound observation tool, dated 02/06/26, showed the following:-The wound on the left ischium is observed to be pressure stage 4. Overall improving, measure 1.9 x 0.3 x 0.3 cm;-No other information related to full body skin assessment. Review of the ADON wound measurements list, dated 02/12/26, showed the following:-Scrotum 10.3 x 5.2 x 2.0, improved;-Left ischium 1.8 x 0.2 x 0.2, improved. During an interview on 02/17/26, at 2:00 P.M., the resident said there were times that his/her wound care did not get completed. He/she did not know if the wounds were improved or stable. The wound had been present for a long time. Review of the wound physician progress notes, dated 02/19/26, showed the following:-Site one - stage 4 pressure wound sacrum full thickness, 11.3 x 3.7 x 1.4 cm, improved evidenced by decreased depth, decreased surface area, decreased undermining;-Site two - stage 4 pressure wound of the left ischium full thickness, 5.8 x 1.3 x 0.3 cm, not at goal due to need more time. Observation on 02/19/26, at 4:10 P.M., showed the following:-Wound care provider, DON, and RN B entered resident room;-Resident did not want additional staff in the room. During an interview on 02/19/26, at 4:20 P.M., Wound Physician stated the undermining on the wound appeared worse but may be due to skin healing over the area. Overall, the surface area was improved. The resident had two wounds, one on the sacrum and one on the ischium into the groin. Recommended continue the current treatment plan. 3. Review of Resident #11's face sheet showed the following: -admitted on [DATE];-Diagnoses included: pressure ulcer of right buttock stage 3 (severe, full-thickness skin loss involving damage to subcutaneous fat, appearing as a deep, open crater), anemia (not having enough healthy red blood cells to carry oxygen to the body's tissues), type 2 diabetes mellitus (chronic condition that affects the way the body processes blood sugar (glucose)). Review of the resident's physician orders current as of 02/24/26 showed the following:-An order dated 01/05/26, start date 01/06/26, cleanse wound to posterior right thigh with wound cleanser; apply hydrofera blue (sterile, non-cytotoxic, absorbent foam wound dressing designed for managing bioburden and promoting healing) to wound; cover with self-adhesive super absorbent dressing; change Tuesday, Thursday, and Saturday and as needed for saturation, soiled or dislodged dressing. Review of the resident's annual MDS, dated [DATE], showed the following:-Cognitively intact;-Use of wheelchair;-Dependent on staff for transfers;-Substantial to maximal assistance required for personal hygiene, dressing, showering, toileting hygiene;-Had unhealed pressure ulcer or injuries;-Had one stage 3 pressure ulcer that was not present on admission. Review of the resident's care plan, last reviewed 12/23/25, showed the following:-Resident had a stage 3 pressure ulcer;-Resident had potential for impairment of skin integrity related to immobility and fragile skin;-Licensed nurse will continue with weekly skin assessment to monitor for new areas of concern;-Wound nurse to document weekly measurement and assessment of wound progress;-Wound care provider will follow wound and progression. Review of the Treatment Administration Record, for the Month of January 2026, showed the following:-An order dated 01/06/26, showed to cleanse the wound to the posterior right thigh with wound cleanser; apply hydrofera blue to wound; cover with self-adhesive super absorbent dressing. Dressing is to be changed Tuesday, Thursday, and Saturday, and as needed, for saturation, soiled or dislodged dressing;-Staff did not document treatment as completed on 01/06/26, 01/08/26, 01/10/26, 01/13/26, 01/20/26, 01/22/26, 01/24/26, or 01/29/26;-Staff did not document that 8 out of 12 dates in January were treatment completed. Review of the Treatment (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administration Record, for the Month of February 2026, showed the following:-An order dated 01/06/26, showed to cleanse the wound to the posterior right thigh with wound cleanser; apply hydrofera blue to wound; cover with self-adhesive super absorbent dressing. Change Tuesday, Thursday, and Saturday and, as needed, for saturation, soiled or dislodged dressing;-Staff did not document treatment as completed on 02/03/26, 02/05/26, 02/07/26, 02/10/26, 02/12/026, 02/17/26, 02/19/26, or 02/21/26;-Staff did not document that 8 out of 9 dates in February were treatment completed. Review of the nursing progress notes showed staff documented the following:-No information related to wound care not completed. Review of ADON wound measurements list, dated 02/12/26, showed the following:-Right posterior thigh, 2.5 x 4.1 x 0.2, improved. Review of the wound physician progress notes showed the following:-On 02/05/26, Pressure wound stage 3 on right thigh, measured 2.5x4.1x0.2cm, with surface area of 10.25cm, no signs of infection, continue current treatment plan three times per week and as needed;-On 02/19/26, Pressure wound stage 3 on right thigh, measured 1.1x5.8x0.2cm, with surface area of 6.38cm, no signs of infection, continue current treatment plan three times per week and as needed. Observation on 02/19/26, at 4:00 P.M., showed the following:-Wound care provider and DON enter the resident's room and donned a gown and gloves; -Assisted the resident to roll to his/her right side;-The blue bandage with date of 02/14/26 was removed;-Observation showed an open area that was approximately 1 by 6 cm, minimal drainage, -Wound Physician stated to continue same treatment;-DON completed wound care and did not date bandage, said he/she would return to date. 4. Review of Resident # 61's face sheet showed the following: -admitted [DATE];-Diagnoses included: type 2 diabetes mellitus with hyperglycemia, peripheral vascular disease (common circulation problem where narrowed or blocked blood vessels reduce blood flow to limbs, organs, and the head, most commonly affecting the legs), pressure ulcer of sacral region stage 2 (partial-thickness skin loss involving damage to the epidermis and dermis, appearing as a shallow, open ulcer with a pink/red wound bed). Review of the resident's quarterly MDS, dated [DATE], showed the following:-Cognitively intact;-Use of walker;-Use of wheelchair;-Setup or clean-up assistance with toileting hygiene, personal hygiene, toileting hygiene;-Supervision or touching assistance with showering, dressing;-Resident at risk for developing pressure ulcer or injuries;-Resident had one stage 2 pressure ulcer present on admission. Review of the resident's care plan, last reviewed 12/18/25, showed the following:-Resident had potential for impairment to skin integrity related to fragile skin;-Staff should report any skin concerns to the physician;-Staff should complete weekly treatment documentation to include measurement of each area of skin breakdowns' width, length, depth, type of tissue and any other notable changes or observations. Review of the Treatment Administration Record, for the Month of January 2026, showed the following:-An order with a start date of 01/26/26 and discontinue date of 02/06/26, showed to cleanse with the coccyx with wound cleanser, apply fibracol (soft, absorbent, non-adherent dressing designed to maintain moist environment that promotes new tissue and rapid healing) to wound bed, cover with bordered foam dressing every night shift every two days for wound care until resolved;-Staff did not document care completed on 01/28/26 or 01/30/26 (2 out of 3 days not documented). Review of the Treatment Administration Record, for the Month of February 2026, showed the following:-An order with a start date of 01/26/26 and a discontinue date of 02/06/26, showed to cleanse the coccyx with wound cleanser, apply fibracol to wound bed, cover with bordered foam dressing every night shift every two days for wound care until resolved;-Staff did not document care completed on 02/01/26 or 02/05/26 (2 out of 3 days not documented);-An order dated 02/06/26, showed Triad hydrophilic wound dress external paste was to be applied to the coccyx topically at bedtime for wound care;-Staff did not document care completed on 02/06/26, 02/08/26, 02/12/26, 02/14/26, 02/15/26, or 02/20/26 (6 out of 17 days not documented). (continued on next page)

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	02/24/2026

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

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the weekly skin observation, dated 02/03/26, showed the following:-Existing skin issue - pressure ulcer stage 2 on coccyx and bilateral upper extremities have bruises that are in the healing process. Review of the wound physician progress notes, dated 02/05/26, showed the following:-Site two - Stage 2 pressure wound coccyx partial thickness, 0.5 x 0.4 x 0.1 cm, present greater than 4 days. Review of the ADON wound measurements list, dated 02/12/26, showed coccyx area closed, resolved, continue triad. Review of the nursing progress notes showed staff documented the following:-No documentation for wound care not completed or resident refusal. Review of the wound physician progress notes, dated 02/19/26, showed the following:-Site two - Stage 2 pressure wound coccyx partial thickness, 0.3 x 0.3 x not measurable cm, depth is unmeasurable due to presence of dried fibrinous exudate (scab - acting as a natural bandage), improved evidenced by decreased surface area. Observation on 02/19/26, at 5:10 P.M., showed the following:-Wound Physician and DON entered the resident's room;-No bandage on the buttocks;-Scab observed on the buttock - continued triad. 5. Review of Resident #25's face sheet showed the following: -admitted on [DATE];-Diagnoses included: chronic kidney disease (CKD - kidneys are damaged and can't filter blood the way they should), severe sepsis (life-threatening medical emergency caused by the body's extreme, dysfunctional response to an infection, which triggers widespread inflammation, tissue damage, and organ failure) without septic shock, bacterial pneumonia (serious lung infection causing inflammation and fluid/pus accumulation in the air sacs). Review of the resident's admission MDS, dated [DATE], showed the following:-Severe cognitive impairment;-Use of walker;-Use of wheelchair;-Partial to moderate assistance with toileting hygiene, showering , personal hygiene, dressing;-Resident at risk of developin

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and record review, the facility failed to ensure the Director of Nursing (DON) worked full time and did not work as the charge nurse when the facility had an average daily occupancy of 60 or more residents. The facility census was 69. Review of the facility's undated job description, Director of Nursing (DON), showed the following:-Our mission is to transform lives through Accountability, Service, Passion, Integrity, Resilience, and Excellence;-The DON is responsible for providing leadership, oversight, and direction to the nursing department to ensure the delivery of high-quality resident care and services;-The DON collaborates with interdisciplinary teams, nursing staff, and healthcare providers to promote resident well-being, clinical excellence, regulatory compliance, and a culture of safety and professionalism;-Key Responsibilities:-Provide visionary leadership, strategic direction, and operational oversight to the nursing department, aligning nursing goals with the facility's mission, vision, and values;-Recruit, hire, train, supervise, and evaluate nursing staff, including registered nurses (RNs), licensed practical nurses (LPNs), certified nursing assistants (CNAs), and other nursing personnel;-Foster a positive and supportive work environment, promoting teamwork, collaboration, open communication, and professional growth among nursing staff members;-Ensure the provision of resident-centered care that meets the physical, emotional, and psychosocial needs of residents, adhering to established care standards, protocols, andbest practices;-Collaborate with interdisciplinary teams to develop and implement individualized care plans, treatment regimens, and interventions based on resident assessments, preferences, and goals;-Monitor and evaluate resident outcomes, quality indicators, and clinical performance metrics, implementing quality improvement initiatives to enhance resident care and safety;-Ensure compliance with federal, state, and local regulations, as well as industry standards and accreditation requirements, related to nursing practice, resident rights, and clinical care;-Coordinate and participate in regulatory surveys, inspections, audits, and compliance reviews, addressing deficiencies and implementing corrective actions as needed;-Conduct ongoing assessments, audits, and monitoring activities to assess nursing department performance, identify areas for improvement, and ensure adherence to policies and procedures;-Develop, implement, and evaluate nursing education and training programs to enhance staff competency, skills, and knowledge in areas such as resident care, clinical procedures, infection control, and safety;-Provide ongoing education, mentoring, and professional development opportunities to nursing staff members, encouraging continuous learning and career advancement;-Collaborate with external resources, educational institutions, and professional organizations to facilitate staff training, certification programs, and continuing education initiatives; -Collaborate effectively with interdisciplinary team members, including physicians, therapists, social workers, dietary staff, and administrators, to coordinate resident care and support interdisciplinary care planning;-Communicate effectively with residents, families, healthcare providers, and external stakeholders regarding resident care plans, treatment goals, care transitions, and clinical updates;-Facilitate interdisciplinary meetings, care conferences, and case reviews to discuss resident progress, address care issues, and promote continuity of care across caresettings;-Develop and maintain nursing-related emergency preparedness plans, policies, and procedures to ensure the safety and well-being of residents and staff during emergencies or disasters;-Coordinate nursing responses to emergencies, crises, and adverse events, implementing protocols for triage, communication, evacuation, and continuity of care;-Provide leadership, guidance, and support to nursing staff members, residents, and families during challenging situations, demonstrating resilience, empathy, and effectiveproblem-solving skills;-The DON plays a pivotal role in ensuring the provision of high-quality resident care, (continued on next page)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	promoting clinical excellence, regulatory compliance, and interdisciplinary collaboration within a Long-Term Care facility;-Through their leadership, expertise, and commitment to nursing excellence, the DON contributes to enhancing resident outcomes, optimizing nursing practice, and fostering a culture of safety, compassion, and professionalism. Review of the facility's nursing schedule, Daily Assignment Sheets, showed the DON as charge nurse:-On 02/08/26, night shift with a census of 70;-On 02/11/26, day shift with a census of 70;-On 02/13/26, day shift with a census of 70;-On 02/16/26, night shift with a census of 69;-On 02/17/26, scheduled night shift with a census of 69; she did not work this shift due to state survey in process;-DON scheduled to work 5 shifts out of 9 days as floor/charge nurse. During an interview on 02/18/26 at 11:20 A.M., LPN B said the DON was often filling in as a charge nurse. The LPN was unsure when the DON would have time to do the DON duties. During an interview on 02/19/26 at 10:40 A.M., the Assistant Director of Nurses (ADON) said she currently worked more than 40 hours per week and was often a charge nurse on the floor. She had not had time to complete audits on wound care and CNA charting. Both her and the DON were putting a lot of hours on the floor and not completing the DON and ADON duties. During an interview on 02/20/26 at 11:40 A.M., the DON said there have been staffing issues. There were staff that would not show up when they said they would. She has worked most weekends and one to two nights per week. She would stay until the morning meeting and then leave. They try to keep two nurses staffed for all shifts. She had not been the only nurse on the days or nights she worked. When she worked on the floor, she was still the DON. She had not had time to audit Treatment Administration Records (TARs) or Medication Administration Records (MARs) weekly due to working on the floor often. During an interview on 02/20/26 at 3:00 P.M., the Administrator said when the DON was working the floor he expected she was the nurse in charge. He was aware she was working on the floor often due to staffing challenges.