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	03/27/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 interview and record review, the facility failed to provide care per standards of practice when staff failed to complete monitoring of bowel movements per physician order and facility protocol, failed to update the care plan after a resident required hospitalization/treatment for constipation/impaction, and failed to notify the physician of multiple refusals of medications for one resident (Resident #1). The facility census was 64.Review of the facility's policy, titled Medication Monitoring, dated 2025, showed the following:-The facility takes a collaborative, systematic approach to medication management, including monitoring medication for efficacy and consequences;-Licensed nurses with periodic oversight by nurse managers, shall report refusals of medications, frequent holding of medications, or signs of adverse consequences of medications to the physician;-Interventions shall be identified on the resident's comprehensive plan of care for the systematic monitoring of high-risk medications to facilitate early identification of adverse consequences;-Target symptoms and goals for use of the medications shall be indicated on the resident's plan of care.Review of the facility's policy, titled Bowel Protocol, undated, showed the following:-The purpose is to establish a standardized approach for assessing, developing, implementing, and monitoring bowel movement regimens for residents, ensuring the promotion of comfort, dignity, and bowel health while preventing constipation, impaction, and related complications; -It is the policy of the to ensure that each resident's bowel function is assessed and managed through an individualized, interdisciplinary plan of care;-Residents will have bowel patterns monitored routinely;-A bowel regimen will be developed when clinically indicated, with input from nursing, medical, and dietary staff, and therapy disciplines as appropriate;-Interventions will be designed to maintain or restore normal bowel function and prevent avoidable constipation, fecal impaction, or incontinence;-Documentation and communication regarding bowel function will occur routinely and be reviewed as part of clinical rounds and interdisciplinary care planning;-Upon admission and quarterly, and with any significant change, the nurse will document bowel status in the electronic medical record (EMR), which includes, but is not limited to bowel sounds, nausea, decreased oral intake and abdominal pain;-The interdisciplinary care team (IDT) will develop an individualized bowel plan of care for residents when appropriate;-A bowel regimen care plan may include interventions including high-fiber foods, adequate fluid intake, activity interventions, encouragement of ambulation or range of motion, stool softeners, laxatives, or suppositories as ordered, and/or consistent timing, positioning, and privacy;-Nursing staff will document bowel movement occurrences, continence, size, and consistency in the EMR;-Nursing staff will receive notification for residents who have no documented bowel movements in the last 72 hours via electronic Medication Administration Record (eMAR) alerts that populate daily;-If no bowel movement is documented, on day three administer 30 cubic centimeters (cc) of milk of magnesia (used to treat constipation) house stock. If no result then day four administer Biscodyl suppository (used to treat constipation) house stock. If there is no result, then on day five give a fleet enema;-The IDT will review bowel regimen effectiveness during the shift-to-shift report;-Any significant changes (impaction, ileus (a condition in which the bowel does not work correctly), dark/bloody stools, etc.) will be promptly reported to the provider and documented in the EMR; -Effectiveness of the bowel (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
	265538	A. Building B. Wing	03/27/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	regimen will be evaluated by nursing and by the provider as clinically indicated;-Regimens will be modified as needed based on resident response, clinical condition, or medication changes;1. Review of Resident #1's face sheet (a document that gives a resident's information at a quick glance) showed the following:-admission date of 01/25/19;-Diagnoses included iron deficiency anemia secondary to blood loss, noninfective gastroenteritis and colitis (inflammatory conditions of the digestive tract not caused by infections, often triggered by food sensitivities, medications or underlying diseases), gastrointestinal hemorrhage (a symptom of an underlying digestive disorder, ranging from mild to life-threatening, often caused by peptic ulcers, hemorrhoids, or cancer), and gastro-esophageal reflux disease (is the most common form of GERD, where patients experience chronic, often severe, heartburn and regurgitation, but have a normal-appearing esophagus during endoscopy).Review of the resident's comprehensive Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 02/20/26, showed the following:-Significant cognitive impairment;-Dependent on staff for transfers;-Incontinent of bowels;-Constipation was not present.Review of the resident's care plan, dated 12/15/25, showed the following:-Requires assistance with functional abilities due to contractures (permanent tightening of the muscles, tendons, skin, and nearby tissues that causes the joints to shorten and become very stiff);-Due to physical debility, the resident does not sit on the toilet. He/she has incontinence of bladder and bowel. Staff to provide a bed pan often and assist with peri care;-Bowel and bladder incontinence due to mobility and cerebral palsy;-The resident may decline to take medications at times, stating it is yucky. It helps if he/she has a friend with him/her to hold his/her hand when medications are administered.Review of the resident's nurses' notes showed the following:-On 11/15/25, at 9:03 A.M., Registered Nurse (RN) D noted the lab called the facility and reported a critical hemoglobin (an iron-rich protein in red blood cells that transports oxygen from the lungs to body tissues) lab of 6.2. Resident refused to let this nurse obtain blood pressure or pulse rate. He/she was not having any pain in his/her stomach, and he/she felt okay. The resident refused to get out of bed. Staff notified the physician of these concerns and received new orders for increased Dexilant (used to treat stomach acid/GERD) to 60 milligrams daily. Staff called family and notified them of lab results and new order;-On 11/15/25, at 1:28 P.M., RN D note the resident began having reddish brown emesis (vomit) that looked like watery coffee grounds. The resident's physician was notified, and he/she ordered resident sent to the emergency room for evaluation and treatment. Staff attempted to reach the resident's power of attorney multiple times with no answer.;-On 11/18/25, at 3:52 P.M., RN A noted the resident returned to the facility from the hospital where the resident was admitted for anemia with three blood transfusions. The resident also had a non-bleeding ulcer cauterized, esophageal dilation (procedure that stretches the esophagus to make swallowing easier), and disimpaction during sedation;-The physician recommended keeping a record of bowel movements.Review of the resident's hospital record, dated 11/15/26, showed the following:-The resident has a history of chronic gastrointestinal tract (GI) blood loss, gastroparesis (the stomach has trouble clearing out its contents), recurrent constipation, large amount of stool burden;-The staff at the facility reported difficulty getting the resident to take his/her medication;-The resident had severe constipation with large fecal impaction;-The physician attempted a stool disimpaction. The resident had an extremely large ball of stool and constipation.Review of the resident's bowel elimination records showed the following: -On 12/02/25, night shift, the resident was incontinent and had a large bowel movement;-On 12/03/25, no documentation by staff; -On 12/04/25, day shift, the resident had no bowel movement;-On 12/05/25, no documentation by staff;-On 12/06/25, no documentation by staff.Review of the resident's medical record showed staff did not document physician notification regarding the residents not having bowel movements. Review of the resident's medical record showed staff did not administer interventions related to no bowel movement from 12/03/25 to 12/06/25. Review of the resident's bowel elimination records showed the following:-On 12/07/25, day shift, the resident was incontinent and had a small bowel movement (four days after the last document bowel (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	03/27/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	movement);-On 12/07/25, night shift, the resident was incontinent and had a small bowel movement;-On 12/08/25, day shift, no documentation by staff. During the night shift the resident had no bowl movement;-On 12/09/25, no documentation by staff;-On 12/10/25, day shift and night shift , the resident had no bowel movement;-On 12/11/25, day shift and night shift, the resident had no bowel movement;-On 12/12/25, day shift and night shift, the resident had no bowel movement;-On 12/13/26, no documentation by staff (six days with no bowel movement).Review of the resident's medical record showed staff document physician notification of the resident not having bowel movements on 12/13/26. Review of the resident's medical record showed staff did not administer interventions related to no bowel movement until 12/13/26. Review of the resident's nurse's note dated 12/13/25, at 11:27 P.M., showed the following: -When he/she arrived at the facility it was reported that the resident did not have a bowel movement in five to six days and had been given a new order of Miralax (used to treat constipation);-The resident had been throwing up the last few nights and tonight had been throwing up coffee ground emesis;-He/she was told to contact family first before sending patient out of the facility by another nurse;-Staff reached the resident's family who asked the nurse to call the physician and see what they wanted to do with resident;-The RN spoke with the physicians on-call and explained the resident's family requested not to have resident sent out if possible. The physician confirmed it was necessary to send the resident to the hospital due to the resident's current status, vital signs, and emesis;-Arrangement made to send out resident;-Nurse called back family prior to calling emergency medical services (EMS) and explained what the physician said. Family gave the okay to send the resident;-The resident was sent to the hospital at around 10:20 P.M.Review of resident's hospital records, dated 12/13/25, showed the following:-The assessment/impression showed acute chronic blood loss anemia (upper GI bleed), stercoral colitis (inflammation inside the colon caused by fecal impaction), fecal impaction (a severe, often painful, form of chronic constipation where a large, hardened mass of stool becomes stuck in the rectum or colon, blocking normal bowel movements), Barrett's Esophagus (condition where the normal tissue lining the esophagus changes to tissue similar to the intestinal lining, usually caused by chronic acid reflux (GERD)), cerebral palsy; and esophageal stenosis (narrowing of the esophagus);-The resident's chief complaint was abdominal pain with associated nausea, vomiting, and constipation;-The resident said he/she had not had a bowel movement in six days at the facility;-The resident was admitted last month for an esophageal ulcer, hematemesis (vomiting blood.), and fecal impaction;-The hospital provider was able to provide a partial stool disimpaction with pain being improved;-The computed tomography (CT - noninvasive imaging test that uses X-rays and computers to create detailed 3D images of bones, soft tissues, and blood vessels, often to diagnose tumors, internal injuries, or infections) results showed moderate stool in the rectal vault and additional moderate-large amount of stool throughout the colon with no bowel obstruction.Review of the resident's February 2026 Treatment Administration Record (TAR) showed the following:-A current order to monitor bowel movements (BM) daily (the resident should have a BM every other day (QOD);-An order, dated 12/28/25, current order to give Dulcolax suppository (stool softener) if no BM every other day, check two times a day;-Staff did not document monitoring on the morning shift on 02/01/26, 02/08/26, 02/13/26, or 02/27/26, and night shift of 02/06/26, 02/09/26, and 02/11/26. Review of the resident's care plan, dated 12/15/25, showed staff did not document regarding the increased monitoring of bowel movements. Review of the resident's nurse's dated 03/03/26, at 2:00 A.M., showed the following: -RN C said resident called nurse to his/her room with complaints of pain in his/her abdominal area. Resident was in distress covered in sweat and pale. The RN called EMS to come STAT (immediately, without delay);-When EMS entered the resident began vomiting black coffee ground emesis into the trash can;-EMS viewed emesis and took the resident to the hospital;-Staff notified the resident's family and physician.During an interview on 03/24/26, at 12:42 A.M., RN A said the following:-He/she monitored the resident bowel movements. The resident had a history of getting constipated and issues with his/her GI tract/ GI bleed;-The resident was on the (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	03/27/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	same bowel monitoring as the other residents prior to a couple of months ago. The staff is expected to follow the facility protocol and intervene if the resident went three days without a bowel movement. The staff can also call the physician if there are concerns;-The resident had to get treatment at the hospital due to constipation. The staff had not been consistent with monitoring the resident's bowel movements;-The resident got orders added after that for monitoring of his/her bowel movements since then;-The certified nursing aides (CNA's) document in the tasks whether the resident had a bowel movement or not and give a description (size and consistency). The CNAs were expected to document each shift;-He/she looked at the records to see if the resident had a bowel movement. If the CNA's didn't document anything then he/she asked them to confirm if the resident had one. The nurses check it off on the MAR;-The nurses give a suppository if the resident went more than a day without a bowel movement per the order;-There were also communication forms that were started recently that would allow the nurses to let each other know if the resident did not have a bowel movement that shift;-He/she thought that the interventions for the resident's constipation would be included in his/her care plan.During an interview on 03/24/26, at 1:15 P.M., the MDS Coordinator said the following:-The resident had a history of constipation that required treatment during his/her hospitalization a few months ago;-The physician added an order for monitoring due to issues monitoring his/her bowel movements;-The resident was on medication to prevent constipation and had orders for monitoring constipation by ensuring the resident was having a bowel movement every other day. The nurses give a suppository if that has not occurred;-The CNA's document in the chart if the resident has a bowel movement;-He/she was in charge of updating the care plans.During an interview on 03/24/26, at 1:36 P.M., CNA B said the following:-He/she did not know the resident had any issues with constipation;-He/she was responsible for documenting in the chart if the resident has a bowel movement. He/she did not know what happened after that.During an interview on 03/24/26, at 3:07 P.M., RN C said the following:-The nursing staff monitor the residents for bowel movements. The staff follow the facility protocols if a resident does not have a bowel movement for more than three days;-He/she could not remember the specifics of the protocol;-The resident had a history of constipation and required interventions. The nurses followed an order to monitor bowel movements and to intervene if the resident did not have one every other day;-He/she checked with the CNA's on his/her shift to see if the resident had a bowel movement;-He/she did not know why the TAR was not checked off. The nurses were responsible for ensuring the MAR/TAR was checked off every shift.During an interview on 03/24/26, at 3:21 P.M., RN D said the following:-The facility did not have the best system for monitoring bowel movements for the residents;-If a resident went more than three days without a bowel movement there was a protocol of medication the nurses were supposed to provide;-If the resident went more than five days without a bowel movement staff inform the physician;-He/she knew the resident required additional monitoring for constipation. The nurses failed to monitor the resident a few months ago and he/she required care at the hospital;-He/she checked the CNA's documentation to see if the resident had a bowel movement that shift or the prior shift. He/She would check off on the TAR that she monitored.During an interview on 03/26/26, at 3:25 P.M., Licensed Practical Nurse (LPN E) said the following:-The nurses monitor the resident every shift for bowel movements to prevent constipation due to having a history of multiple hospitalizations related to constipation;-The nurses document on the TAR what it was done. It was important to complete the monitoring because a suppository was ordered to be administered if the resident did not have a bowel movement every other day;-The nurses have a protocol for all residents regarding bowel movements and generally the nurse should intervene if the resident has not had a bowel movement in three days;-He/she did now know if anyone monitored that.During an interview on 03/26/26, at 3:48 P.M., CNA F said the following:-He/she documented in the chart if a resident had a bowel movement including the size and consistency so the nurses can track it. The nurses used that to check off the TAR;-Staff closely monitored the resident for bowel movements because he/she would get very constipated quickly and had to go to the hospital. During an interview on 03/27/26, at 12:11 A.M., (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	03/27/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Certified Mediation Tech (CMT) G said staff monitored the resident for bowel movements. The CNA's documented bowel movements and the nurse monitored them to ensure if an intervention was not required.During interviews on 03/27/26 and 3/30/26, at 8:31 A.M., the resident's physician said the following:-The resident had issues with his/her entire GI tract including the esophagus. He/she was being treated with medication for ulcers and constipation;-The resident was hospitalized a few months ago for upper GI issues and was constipated;-He/she expected staff to closely monitor the resident for constipation;-He/she gave the facility a protocol to follow if a resident does not have a bowel movement. The nurses administer Milk of Magnesia if the resident has not had a bowel movement in three days . If that is unsuccessful then the nurses administer a Dulcolax suppository on the fourth day. On the fifth if the resident is still not successful in having a bowel movement, then the nurse contacts the physician for further orders;-He/she expected the nurses would follow the orders and complete documentation such as checking off the TAR.During an interview on 03/27/26, at 11:38 A.M., the Assistant Director of Nursing (ADON) said the following:-The resident had a history of constipation that resulted in him/her going to the hospital;-The CNA documents the resident's bowel movements in the chart. The nurse should be checking that to ensure residents were having bowel movements and follow the facility protocol;-The resident had increased monitoring, and the nurses should check with the CNA and document the monitoring on the TAR by checking it off.During interviews on 03/27/26, at 11:01 A.M. and 5:14 P.M., the Director of Nursing (DON) said the following:-The resident had a history of constipation;-The resident went to the hospital in December 2025;-He/she was not aware that the resident had gone five days without a bowel movement and no added intervention being provided until after the fact;-The nurses follow the facility protocol for bowel movements. The staff intervene if a resident does not have a bowel movement in three days if they still don't have a bowel movement by day five staff call the physician. The resident went to the hospital on the sixth day and was found to be constipated and impacted;-The resident was placed on increased monitoring with an order for monitoring of bowel movements by the nurses every shift to ensure he/she was having one every other day;-The nurses checked the chart for the bowel movement documentation from the CNA's and checked that off on the TAR every shift;-He/she did not know why the task on the TAR was not checked off;-The nurses provide a suppository if the resident did not have a bowel movement every other day.During an interview on 03/27/26, at 3:18 P.M., the Administrator said the following:-He/she expected the staff to follow physician orders/ protocols and the MAR/TAR to be completed;-He/she expected staff to follow the interventions for constipation as ordered. Review of the resident's February 2026 Physician Order Sheet (POS) showed an order, dated 12/15/15, for baclofen (muscle relaxer), give five mg by mouth two times a day for muscle rigidity.Review of the resident's February 2026 Medication Administration Record (MAR) showed staff documented the resident refused the baclofen 02/03/26, 02/05/26, 02/07/26, 02/08/26, 02/09/26, 02/10/26, 02/14/26, 02/16/26, 02/19/26, 02/21/26, 02/22/26, 02/24/26, 02/25/26, and the evening on 02/04/26, 02/07/26, 02/11/26, 02/13/26, 02/14/26, 02/18/26.Review of the resident's February 2026 POS showed an order, dated 01/25/19, for Biscodyl tablet delayed release 5 mg, give two tablets orally one time a day for constipation.Review of the resident's February 2026 MAR showed staff documented the resident refused the Biscodyl on 02/03/26, 02/05/26, 02/07/26, 02/08/26, 02/09/26, 02/10/26, 02/14/26, 02/16/26, 02/19/26, 02/22/26, 02/24/26, and 02/25/26.Review of the resident's February 2026 POS showed an order, dated 12/15/25, for Carafate oral tablet (antiulcer medication), give one tablet by mouth two times a day for a gastrointestinal bleed.Review of the resident's February 2026 MAR showed staff document the resident refused the Carafate the morning of 02/3/26, 02/05/26, 02/07/26, 02/08/26, 02/09/26, 02/10/26, 02/14/26, 02/16/26, 02/19/26, 02/22/26, 02/24/26, 02/25/26 and in the evening on 02/04/26, 02/07/26, 02/11/26, 02/13/26, 02/14/26 , and 02/18/26.Review of the resident's February 2026 POS showed an order, dated 10/18/23, for Colace capsule (stool softener), give 100 mg by mouth two times a day for constipation, dated 10/18/23.Review of the resident's February 2026 MAR showed staff documented the resident (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	03/27/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	refused the Colace capsule in the morning on 02/03/26, 02/05/26, 02/07/26, 02/08/26, 02/09/26, 02/10/26, 02/14/26, 02/16/26, 02/19/26, 02/21/26, 02/22/26, 02/24/26, 02/25/26 and in the evening on 02/04/26, 02/07/26, 02/11/26, 02/13/26, 02/14/26, and 02/18/26.Review of the resident's February 2026 POS showed an order, dated 12/29/26, for Dexilant Oral Capsule delayed release 60 mg, give one capsule by mouth one time a day related to gastro-esophageal reflux disease without esophagitis.Review of the resident's February 2026 MAR showed staff documented the resident refused the Dexilant oral capsule on 02/03/26, 02/05/26, 02/07/26, 02/08/26, 02/09/26, 02/10/26, 02/14/26, 02/16/26, 02/19/26, 02/22/26, 02/24/26, and 02/25/26.Review of the resident's February 2026 POS showed an order, dated 01/30/26, for ferrous sulfate (iron) oral solution, give five ml by mouth one time a day for anemia concentration of the solution 325mg/5militer (ml).Review of the resident's February 2026 MAR showed staff documented the resident refused the Ferrous sulfate oral solution on 02/03/26, 02/05/26, 02/07/26, 02/08/26, 02/09/26, 02/10/26, 02/14/26, 02/16/26, 02/19/26, 02/26, 02/24/26, and 02/25/26.Review of the resident's February 2026 POS showed an order, dated 10/05/20, for folic acid tablet, give one tablet by mouth one time a day for anemia.Review of the resident's February 2026 MAR showed staff documented the resident refused the folic acid tablet on 02/03/26, 02/05/26, 02/07/26, 02/08/26, 02/09/26, 02/10/26, 02/14/26, 02/16/26, 02/19/26, 02/22/26, 02/24/26, and 02/25/26.Review of the resident's February 2026 POS showed an order, dated 06/06/24, for metoprolol succinate ER (used to treat high blood pressure)oral tablet extended release 24-hour 25 mg, give one tablet by mouth one time a day for atrial fibrillation, hold if blood pressure is lower than 110/70 millimeters/Mercury (mm/Hg).Review of the resident's February 2026 MAR showed the staff documented the resident refused the metoprolol succinate ER [DATE], 02/05/26, 02/07/26, 02/08/26, 02/09/26, 02/10/26, 02/14/26, 02/16/26, 02/19/26, 02/22/26, 02/24/26, and 02/25/26.Review of the resident's February 2026 POS showed an order, dated 12/12/25, for Miralax powder 17gram(gm)/scoop, give one scoop by mouth one time a day for bowel regimen.Review of the resident's February 2026 MAR showed staff documented the resident refused the Miralax on 02/03/26, 02/05/26, 02/07/26, 02/08/26, 02/09/26, 02/10/26, 02/14/26, 02/16/26, 02/19/26, 02/21/26, 02/22/26, 02/24/26, and 02/25/26. Review of the resident's February 2026 POS showed an order, dated 04/04/24, for pravastatin sodium (reduces cholesterol levels) oral tablet 10 mg, give one tablet by mouth in the evening for hyperlipidemia (high cholesterol).Review of the resident's February 2026 MAR showed staff documented the resident refused the pravastatin sodium on 02/04/26, 02/07/26, 02/13/26, 02/14/26, 02/18/26 and 02/21/26.Review of the resident's February 2026 POS showed an order, dated 06/26/25, for Remeron (antidepressant) oral tablet, give 7.5 mg by mouth.Review of the resident's February 2026 MAR showed staff documented the resident refused the Remeron on 02/04/26, 02/07/26, 02/11/26, 02/13/26, 02/14/26, and 02/18/26.Review of the resident's February 2026 POS showed an order, dated 10/18/23, for Senna-S tablet 8.6-50 mg, give two tablets by mouth two times a day for constipation.Review of the resident's February 2026 MAR showed staff documented the resident refused the Senna-S in the morning 02/03/26, 02/05/26, 02/07/26, 02/08/26, 02/09/26, 02/10/26, 02/14/26, 02/16/26, 02/19/26, 02/21/26, 02/22/26, 02/24/26, and 02/25/26 and in the evening on 02/04/26, 02/07/26, 02/11/26, 02/13/26, 02/14/26, and 02/18/26.Review of the resident's medical record showed staff did not document physician notifications of the resident's medication refusals in February 2026. During an interview on 03/24/26, at 12:42 A.M., RN A said the following:-The resident refused medications;- He/she did not know how many refusals before he/she needed to let the physician know;-He/she informed the physician if the resident was consistently refusing and used his/her nursing judgment;-He/she thought the physician was aware;-The resident took medication from certain staff for better than others. They always encouraged him/her to take the medications and made multiple attempts;-He/she had not spoken to the physician about the resident's refusals of his/her medication;-He/she did not know the resident had refused his/her medication over 10 times in the month of February 2026, but he/she thinks if it was multiple days in a row, he/she would tell the (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	03/27/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	physician.During an interview on 03/24/26, at 1:15 P.M., the MDS Coordinator said the following:-He/she knew the resident refused medications. He/she added it to the care plan;-The nurse informs the physician and writes a note in the chart if the refusals are consistent;-He/she did not know if the physician was notified. During an interview on 03/24/26, at 3:07 P.M., RN C said the following:-He/she knew that sometimes the resident would refuse his/her medication;-It didn't happen very often on his/her shift;-He/she believed that the physician was aware but did not remember specifically telling him/her about it;-It should be documented if there was a conversation with the physician.During an interview on 03/24/26, at 3:21 P.M., RN D said the following:-The resident had behaviors and would refuse his/her medication. The staff always encouraged the resident to take it but sometimes it did not work;-He/she did not contact the physician every time the resident refused but believed he/she was aware;-He/she was not sure how many times the resident can refuse before letting the physician know;-It would be hard to know if the resident had refused the days prior because the computer does not alert you.During an interview on 03/26/2,6 at 3:25 P.M., LPN E said the following:-The resident refused his medication sometimes and the staff would encourage him to take them;-He/she did not know if the physician was notified about the resident's refusals of medication;-He/she did not know how often the resident refused medications;-He/she would let the physician know if a resident refused medications multiple days in a row and document it in a nurse's note.During an interview on 03/27/26, at 12:11 A.M., CMT G said the following:-The resident refused medications sometimes;-He/she could generally get the resident to take them;-He/she let the nurse know if the resident did not take his/her medications and would try again later;-He/she did not know if the physician was informed the resident refused medications, but he/she thought the nurse would let the physician know and document that.During interviews on 03/27/26 and 3/30/26, at 8:31 A.M., the resident's physician said the following:-He/she knew the resident would refuse medications sometimes but did not know he/she had refused over 10 times in February 2026;-He/She did not know he/she was refusing so often;-He/she wanted to know if the resident was refusing medication so often. During an interview on 03/27/26, at 11:38 A.M., the ADON said the following:-The resident refused medication often and the staff attempted several times;-The nurses notifies the physician if the resident refuses medication more than once a day and the nurse adds a note to the chart that the resident refused. During interviews on 03/27/26, at 11:01 A.M. and at 5:14 P.M., the DON said the following:-The resident refused medication sometimes, but the physician was aware;-The staff encouraged him/her to take them. During an interview on 03/27/26, at 3:18 P.M., the Administrator said the following:-He/she knew the resident would refuse cares and medications sometimes;-He/she expected staff to contact the physician if the resident was refusing medication consistently.#2809217 and #2808816