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

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to send notification in writing to the resident and/or the resident's representative of a transfer or discharge to a hospital, including the statement of appeal rights or the name, address, or the telephone number of the Office of the State Long Term Care Ombudsman (advocate for the resident in nursing facilities) within the transfer and discharge notices and bed-hold policy (the holding or reserving a resident's bed while the resident is absent from the facility for therapeutic leave or hospitalization) for two residents (Resident #1 and #5); failed to send the notification in writing of a transfer or discharge of a resident from a skilled nursing facility to an assisted living facility for one resident (Resident #75); and failed to send a copy of the transfer or discharge to the Office of the State Long Term Care Ombudsman for three residents (Resident #1, #5, #75). The facility census was 69. Review of the facility's undated policy titled Transfer and Discharge, showed the following:- It is the policy of this facility to permit each resident to remain in the facility, and not transfer or discharge the resident from the facility except in limited situations when the health and safety of the individual or other residents are endangered;-Transfer refers to the movement of a resident from a bed in one certified facility to a bed in another certified facility when the resident expects to return to the original facility;- The facility may initiate transfers or discharges in the following Limited circumstances:- The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;-Emergency Transfers/Discharges - initiated by the facility for medical reasons, or for the immediate safety and welfare of a resident (nursing responsibilities unless otherwise specified);-Obtain physicians' orders for emergency transfer or discharge, stating the reason the transfer or discharge is necessary on an emergency basis;-Notify resident and/or resident representative;-Contact an ambulance service and provider hospital, or facility of resident's choice, when possible, for transportation and admission arrangements;-Complete and send with the resident (or provide as soon as practicable) a Transfer Form which documents:-Resident status, including baseline and current mental, behavioral and functional status and recent vital signs;-Current diagnosis, allergies and reasons for transfer/discharge;-Contact information of the practitioner responsible for the care of the resident;-Resident representative information including contact information;-Current medications (including when last received), treatments, most recent relevant lab and/or radio logical findings and recent immunizations;-Special instructions or precautions for ongoing care to include precautions such as isolation or contact;-Special risks such as risk for falls, elopement, bleeding or pressure injury and/or aspiration precautions;-Comprehensive care plan goals, and;-Any other documentation, as applicable, to ensure a safe and effective transition of care.-A copy of any Advance Directive, Durable Power of Attorney, DNR or Withholding or Withdrawing of Life-Sustaining Treatment forms should be sent with the resident;-The original copies of the transfer form and Advance Directive accompany the resident. Copies are retained in the medical record;-Provide orientation for transfer or discharge to minimize anxiety and to ensure safe and orderly transfer or discharge, in a form and manner that the resident can understand;-Document assessment findings and other relevant (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	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

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	information regarding the transfer in the medical record;- Provide a notice of the resident's bed hold policy to the resident and representative at the time of transfer, as possible, but no later than 24 hours of the transfer;-Provide transfer notice as soon as practicable to resident and representative;-Social Services Director, or designee, shall provide notice of transfer to a representative of the State Long-Term Care Ombudsman via monthly list;-In case of discharge, notice requirements and procedures for facility-initiated discharges shall be followed. Review of the facility's policy, dated February 2024, titled Bed Hold Policy, showed the following:-TRANSFERS. Before and at the time Facility transfers Resident for hospitalization or therapeutic leave. Facility will provide Resident or Resident's Representative with written notice explaining the duration of the bed-hold policy;-MEDICAID. If resident's care at Facility is being paid for by Medicaid. Facility willreserve Resident's bed while the Resident is on therapeutic leave, for any period that is a Covered Service under the program for which Resident is eligible If Resident's absence from Facility exceeds the time covered or is due to hospitalization, we will automatically reserve the bed for 10 days If the resident's absence exceeds 10 days, we will continue to reserve the bed only if someone has signed this Bed Reservation Agreement agreeing to be personally responsible for the charges to reserve the bed The Bed Reservation charge will be equal to 100% the Basic Daily Rate applicable to the bed in question for each day the bed is to be reserved;- MEDICARE. If resident's care at Facility is being paid for by Medicare Facility will automatically reserve the bed for 10 days if absence Is due to a hospital leave If Resident's absence from Facility exceeds this time or is due to a therapeutic leave. we will automatically reserve or continue to reserve the bed only 1f someone has signed the Bed Reservation Agreement agreeing to be personally responsible for the charges to reserve the bed The Bed Reservation charge will be equal to 100% the Basic Daily Rate applicable to the bed in question for each day the bed is to be reserved;-PRIVATE PAY. During any time that Resident's care Is not covered by Medicaid orMedicare. Facility will reserve Resident's bed only if someone has signed this Bed Reservation Agreement agreeing to be personally responsible for the charges to reserve the bed The Bed Reservation charge will be equal to 100% the Basic Daily Rate applicable to the bed in question for each day the bed is to be reserved;-AUTOMATIC RESERVATION. If the Bed Reservation Agreement is signed we will reserve Resident's bed until: Resident returns to Facility; you notify us in writing of your intention to terminate this Agreement; or it is determined that Resident's needs cannot be met at Facility;-NO AUTOMATIC RESERVATION. If there is no signed request for a bed to be reserved automatically you may still request that the bed be reserved but must do so within 24 hours of the Resident's departure from Facility. If the bed is not reserved, Resident will be readmitted to the first available bed in a semi-private room in Facility if Resident continues to require our services and is eligible for Medicaid nursing facility services. 1. Review of Resident #1's face sheet (brief information sheet about the resident) showed the following: -admitted on [DATE];-Diagnoses included: Displaced intertrochanteric fracture (common type of hip fracture) of left femur (bone of the thigh), Sepsis (life-threatening medical emergency caused by the body's extreme, dysfunctional response to an infection, leading to widespread inflammation, tissue damage, and potential organ failure);-Resident had a guardian and was not his/her own responsible party. Review of the resident's Minimum Data Set (MDS - a federally mandated comprehensive assessment completed by facility staff) list in the medical record showed the following:-admitted on [DATE];-discharged with return anticipated 11/03/25;-re-admitted on [DATE]. Review of the resident's nurse progress notes showed staff documented the following:-On 11/03/25, at 3:25 A.M., the resident finally agreed to go to the emergency room for evaluation and treatment post fall, ambulance transporting to hospital, Left facility via ambulance at 3:20 A.M.;-On 11/03/25, at 8:30 A.M., Residents family member was called this morning and was updated on resident status and ambulance transfer to hospital. Per family member the guardian is to be contacted;-On 11/04/25, at 8:23 P.M., the resident arrived to facility via transport at 6:59 P.M. Review of the resident's medical records showed staff did not have documentation regarding a written transfer notice given and/or mailed to the resident and/or (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

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident's representative pertaining to a hospital transfer on 11/03/25. Review of the Bed Hold Acknowledgement Form, showed the following:-On 11/03/25, resident was transferred out of the facility;-Signature below indicated that the bed hold policy was acknowledged at discharge;-Verbal consent by resident, two nurses signatures;-No bed hold policy or information related to resident bed-hold rights, policy, and duration upon transfer in the notice. 2. Review of Resident #5's face sheet showed the following: -admitted on [DATE];-Diagnoses included: Cerebral infarction (stroke), hemiplegia (complete inability to move one side) and hemiparesis (mild to moderate weakness) of right dominant side, aphasia (language disorder caused by brain damage that impairs the ability to speak, understand, read, and write) following cerebral infarction;-Resident was not his/her own responsible party. Review of the resident's MDS list in the medical record showed the following:-admitted on [DATE];-discharged with return anticipated on 10/27/25;-re-admitted on [DATE];-discharged with return anticipated on 11/14/25;-re-admitted on [DATE]. Review of the Bed Hold Acknowledgement Form, showed the following:-On 10/27/25, resident was transferred out of the facility;-Notification was made to the resident's representative;-Signature below indicated that the bed hold policy was acknowledged at discharge;-Verbal consent by resident's representative via phone;-One nurse signature;-No bed hold policy or information related to resident bed-hold rights, policy, and duration upon transfer in the notice. Review of the Bed Hold Acknowledgement Form, showed the following:-On 11/14/25, resident was transferred out of the facility;-Notification was made to the resident's representative;-Signature below indicated that the bed hold policy was acknowledged at discharge;-Verbal consent by resident's representative via phone;-One nurse signature;-No bed hold policy or information related to resident bed-hold rights, policy, and duration upon transfer in the notice. Review of the resident's medical records showed staff did not have documentation regarding a written transfer notice given and/or mailed to the resident and/or resident's representative pertaining to a hospital transfer on 10/27/25 or 11/14/25. Review of the Ombudsman Letter - Month October 2025, showed the following:-Hospital 8 residents (no names or information related to location of transfer). Review of the Ombudsman Letter - Month October 2025, showed the following:-Hospital 6 residents (no names or information related to location of transfer). 3. Review of Resident #75's face sheet showed the following: -admitted on [DATE];-Diagnoses included: Bacterial infection (illness caused by harmful bacteria which can damage tissues), resistant to multiple antibiotics, unspecified psychosis (person exhibits symptoms of a mental disconnect from reality but does not meet full criteria for a specific psychotic disorder);-Resident had a guardian and was not his/her own responsible party. Review of the resident's MDS list in the medical record showed the following:-admitted on [DATE];-discharged with return not anticipated on 01/04/26. Review of the resident's nurse progress notes showed no information documented related to discharge from the facility. Review of the resident's Discharge Planning Review, dated 01/02/26, showed the following:-Resident at facility for wound care and intravenous (IV) antibiotic (medications delivered directly into the bloodstream through a vein, allowing for rapid, high-concentration treatment of severe or resistant bacterial infections);-Resident will be returning to assisted living facility;-Resident signed and nurse signed discharge and dated 01/04/26. Review of the resident's medical records showed staff did not have documentation regarding a written transfer notice given and/or mailed to the resident and/or resident's representative pertaining to the discharge to the assisted living on 01/03/26. Review of the Ombudsman Letter - Month January 2026, showed the following:-No information related to discharge to another facility. 4. During an interview on 02/23/26, at 9:50A.M., Licensed Practical Nurse A said that when sending a resident to the hospital he/she would send transfer discharge profile that included active medications, code status, resident representative information. He/she would call the responsible party and notify of transfer and bed hold and get two nurse to witness the call. He/she would keep copy in the chart. He/she did not send any written information to resident or resident representative. During an interview on 02/23/26, at 10:00 A.M., Registered Nurse B said when transferring a resident to the hospital or completing a (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

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident discharge, he/she would send resident medication list, code status, and any pertinent lab work with the resident. He/she would contact the responsible party and verbally notify them of the transfer and of the bed hold policy. If the resident was their own person and able to sign the bed hold acknowledgement, he/she would have them sign. There was not a bed hold policy that he/she gave to the resident or representative, just a verbal notice of bed hold. He/she did not send any written information to resident or resident representative. During an interview on 02/23/26, at 10:30 A.M., Business Office Manager said the nursing staff completed the bed hold during a transfer to the hospital. The nursing staff leave a copy for him/her. He/she checked in the mornings if any residents had been transferred and asked for the bed hold if not given a copy. He/she did not send any written information to resident or resident representative. During an interview on 02/23/26, at 10:35 A.M., Social Services Director said he/she notify the ombudsman monthly of hospital discharged . The nursing staff contact the resident's family or representative by phone. He/she did not send any written information to resident or resident representative. He/she did not send any resident name information to Ombudsman. He/she only sent a list that showed the number of persons for each category, the Ombudsman requested it that way and did not need the resident's name or where they were sent to. During an interview on 02/23/26, at 10:40 A.M., Director of Nursing (DON) said the nursing staff give a bed hold to the resident and contact the family or representative by phone. If the nursing staff received a verbal response related to the bed hold from the family or responsible party, then two nurses would witness the call. The nursing staff and the DON did not send any written notice of transfer or bed hold to the family or the resident. During an interview on 02/23/26, at 1:44 PM, State Long Term Care Ombudsman said [NAME] Payne - notes that she is only required to enter numbers into her system - she did not know the regulations if needed resident names. He/she said they will soon not need any information as the facility will be required to enter into a website. During an interview on 02/24/26, at 10:00 A.M., Administrator said the nursing staff should contact the resident's representative or family by phone to notify of transfer and should receive a bed hold acknowledgment. He was not aware of any written information to be sent to the resident or representative.

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

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 - 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 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, 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 (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

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 - Some	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., 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 (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

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 - Some	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 (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 (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

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 - Some	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 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 (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

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 - Some	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 02/19/26, at 3:45 P.M., Primary Care Physician said that she expected staff to follow the orders and if had questions that could contact her. Said if staff did not complete wound care it would not get better. If there was a noted decline in wound healing that might be a sign the care was not getting done. The staff should document according to policy, if it was not documented it was considered not done. 10. During an interview on 02/19/26, at 6:00 P.M., Wound Physician stated that overall, the wounds were improved, with only minimal changes or decline in wounds. Stated if the facility did not complete wound care there could be a decline in wound healing progression. The staff should complete wound care according to physician orders and should follow their facility protocol for charting. If there were changes in wound progress or decline during the staff's wound care they should contact the wound care provider or the resident's primary care provider to update and check if different orders recommended. 11. During an interview on 02/20/26, at 11:40 A.M., DON said floor nurses complete weekly skin assessments and should do this as scheduled. The ADON completes wound tracking and had not been able to do wound care due to more residents and busy with other infection control processes. There are standing order that can be initiated when a wound started and then notify the primary physician and wound physician if needed. The standard for wound care is to date the bandage but some concerns of the ink soaking through the dressing. The staff should always document in the TAR, even if refused there was a code for not done and the chart in the progress notes why not done. There should not be blanks on the TAR. If it was not charted it was considered not done. She should be auditing the TAR's weekly but had not had time to do that due to staffing issues. She was not sure if the wound were improving. 12. During an interview on 02/23/26, at 10:00 A.M., Administrator said staff should follow physician orders and complete resident cares. The staff should document all work done and not done. If it was not documented, it was not done.

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

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 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 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 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, (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

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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 (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

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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 (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

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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 (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

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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 (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

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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 (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

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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). 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

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

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 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. Based on interview and record review, facility staff failed to post nursing staff information in a prominent, readily accessible area on a daily basis. The census was 69. Review of the facility records did not show a policy regarding posted nurse staffing. Observation on 02/17/26 at 11:05 A.M., showed a nurse staff hours posting located near the nurses' station next to the dining room window, on the wall at approximately 5 feet high, that showed the following:-Dated 02/12/26 (5 days prior);-Census 70;-Day shift: 2 Registered Nurse (RN)/Licensed Practical Nurse (LPN) = 24 hours, 12 Certified Medication Technician (CMT)/Certified Nurse Aide (CNA) = 123 hours, Total = 147 hours;-No night shift hours were listed. Observation on 02/18/26 at 10:30 A.M., showed a nurse staff hours form located near the nurses' station that showed the following:-Dated 02/18/26;-Census 69;-Day shift: 2 RN/LPN = 24 hours, 11 CNA/CMT = 108 hours, 13 total = 132 hours;-Night shift: 2 RN/LPN = 24 hours, 7 CNA/CMT = 69 hours, 9 total = 93 hours. Observation on 02/19/26 at 1:06 P.M., showed a staff hours posting located near the nurses' station that showed the following:-Dated 2/19/26;-Census 69;-Day shift: 2 nurse = 23 hours, 11 CNA/CMT = 118.5 hours, 13 total = 141.5 hours;-Night shift: 3 nurse = 27 hours 7 aides = 60 hours, 10 total = 87 hours. Observation on 02/20/26 at 2:30 P.M., showed no nurse staff hours posted. Observation on 02/23/26 at 11:00 A.M., showed no nurse staff hours posted. Observation on 02/23/26 at 1:00 P.M., showed a nurse staff hours posting located near the nurses' station on a clipboard with multiple days posting located behind the front sheet. The top sheet showed the following:-Dated 02/24/26 (for the following day);-Census 69;-Day shift: 2 RN/LPN=24 hours, 15 CNA/CMT= 143 hours, 17 total = 167 hours-Night shift: 2 nurse = 24 hours, 7 aides = 70 hours, 9 total = 94 hours. Observation on 02/24/26 at 11:00 A.M., showed a nurse staff hours posting located near the nurses' station that showed the following:-Dated 02/24/26;-Census 69;-Day shift: 2 RN/LPN=24 hours, 15 CNA/CMT= 143 9 hours, 17 total = 167 hours-Night shift: 2 RN/LPN = 24 hours, 7 CNA/CMT = 70 hours, 9 total = 94 hours. During an interview on 02/23/26 at 10:00 A.M., RN B said the nurse staff hours were posted by the night nurse. Then the administration follows up in the morning. It should include the facility census and the staff hours for each shift. During an interview on 02/23/26 at 11:30 A.M., the Director of Nurses (DON) said the night shift nurses should post the daily nurse staffing hours. Last night (02/22/26) a new contract nurse worked, the forms were located in the DON office and the nurse did not have access to the form. The form should be posted daily. During an interview on 02/24/26 at 1:55 PM, the Assistant Director of Nurses (ADON) said she was responsible for posting the nurse staff hours and it should be posted daily. The staff on each shift should make any changes as needed. She said it should be posted every day, even if she was not at work. She had shown the nurses how to complete the form using the daily schedule. During an interview on 02/24/26 at 3:24 P.M., the Administrator said the nurse staff hours should be posted daily. The DON and ADON were responsible for ensuring it was posted.

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

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 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to have a process in place for initial and periodic bed rail safety checks, to include measurements of the bed frame and bed rails for risk of entrapment, for two residents (Residents #9, #18). The facility census was 69.Review of the facility policy, dated 09/17/25, titled Bed and Assist Bars Use in Long-Term Care, showed the following:-To ensure safe and appropriate use of bed rails, side rails, and assist bars to prevent falls, entrapment, and injury, while complying with CMS and state regulations;-Bed rails or assist bars may only be installed or used with a physician/ provider order;-Orders must specify: type of device, purpose, frequency of use, and any resident-specific precautions.-Nursing/Therapy staff must perform a risk assessment prior to implementation, considering: Fall risk, Cognitive status, Mobility level, Skin integrity, Entrapment risk;-Alternative interventions must be considered before use;-Findings and rationale must be documented in the resident's care plan;-Obtain informed consent from the resident or legal representative prior to installation; -Explain risks, benefits, and alternatives;-Only trained staff may install or adjust assist bars or bed rails;-Ensure proper positioning to minimize entrapment and injury risk;-Residents with assist bars/bed rails must be monitored for safety, comfort, and skin integrity;-Reassess necessity at least monthly or when resident condition changes;-Remove assist bars or bed rails when no longer medically necessary;-Update physician orders and care plan accordingly;-Nursing Staff: Perform assessments, ensure order is in place, monitor safety;-Physician/ Provider: Evaluate necessity, write orders, review ongoing use.-Therapists: Perform assessments, recommend safer alternatives or modifications if appropriate. Review of the facility undated form, titled Bed Rails and Turn Bars Informed Consent for Use, showed the following:-Based on the assessment and identifications of the resident's needs. bed rails may be beneficial for the following reasons:-Safety: Can serve as a safety measure by preventing falling or slipping onto floor by resident with but not limited to the following conditions: seizures, neurological or movement disorders;-Security: Can provide a sense of security if the resident is afraid of falling, his/her movement iscompromised or accustomed to sleeping in a larger bed;-Mobility Assistance: Con assist resident to reposition self in bed upward/downward or turning side-to-side. Can also assist resident with safely exiting or entering bed;Potential Risks and Negative OutcomesThe use of bed rails can present a hazard or involve potential risks to certain individuals, particularly those residents with physical limitations or altered mental status, such as delirium or dementia. Potential risks may include getting caught within the roil, getting caught between mattress and rail, strangulation, suffocation, bruising and/or skin tears caused by hitting against rails, crawling over the rails and falling from greater heights increasing risk for serious injury or death. Other potential negative outcomes may include, but ore not limited to, decline in muscle functioning, skin integrity issues, may alter resident's self-esteem, induces agitation or anxiety, feelings of isolation, decline in other areas of activities of daily living and reduced physical mobility;-It is the policy of this facility to use bedrails only after on individualized resident assessment, evaluation and core planning by on interdisciplinary team determine it beneficial and appropriate for use to treat the resident's medical symptoms, assist the resident in attaining or maintaining the highest possible physical and psychosocial well-being and after attempts at using alternatives [NAME] proven inadequate or inappropriate. In determining bed rail use, the least restrictive device, which is effective, will be used.-The facility will monitor the resident's status, frequency of use, and adjust care as needed;-The facility will have a systematic evaluation process to gradually decrease and/or eliminate the use of bed rails to ensure the resident's safety while treating the resident's medical symptoms;-What assessed medical needs for this resident would be addressed by the use of bed rails or turn bars?-What are the benefits of using bed rails or turn bars for this resident and what is the likelihood of thesebenefits?-What are 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	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

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 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident's potential risks from the use of bed rails or turn bars?-Ways these risks will be mitigated;-Alternatives attempted that failed to meet resident's needs;-Alternatives considered but not attempted because they were considered inappropriate;-Recommended Type of Bedrails or Turn Bars:-Full Length Rail, Left Upper and/or Lower, Right Upper and/or Lower;-Three quarter Length Rail, Left Upper and/or Lower, Right Upper and/or Lower;-One-half Length Rail Left Upper and/or Lower, Right Upper and/or Lower;-One-quarter Length Rail Left Upper and/or Lower, Right Upper and/or Lower;-Split Roil Left Upper and/or Lower, Right Upper and/or Lower;-Turn Bar Left Upper and/or Lower, Right Upper and/or Lower;-Turn bar also referred to as assist bar or cone assist bar;-Recommended Frequency of Use:-Recommended bed rails or turn bars be used only at night;-Recommended bed rails or turn bars be used at all times while resident is in bed;-Recommended bed rails or turn bars be used only when resident is asleep;-I acknowledge that I have been informed of having medical needs that would be addressed by the useof bed rails or turn bars. I certify that I have read the benefits and potential risks/negative outcomes ofbed roil use, or this information has been read and explained to me. I certify that I fully understand themedical needs, benefits and potential risks/negative outcomes of bed rail use, and the health coreprofessionals' evaluation/recommendations. Therefore: -I DO voluntarily consent to the use of bed rails or turn bars as recommended;-I DO NOT consent to the use of bed rails or turn bars as recommended and understand liabilities. Review of the facility undated form, titled Bed Rails and Mattress Safety Assessment, showed the following:-Resident name and Room number;-Date of Assessment;-Reason for Assessment:-Initial Use. Scheduled Review. Change in Mattress. Change in Bed. Change in Rail.Type of bed. Type of mattress. Type of rail;-The gap between the mattress and the lowermost portion of the bed rail can be no greater than 2.5 inches or ____ for this resident;-The gap between the inside surface of the bed rail and the mattress can be no greater than 4.5 inches or _____ for this resident;-Measure while resident ls in the bed;-Implement corrective action or do not use rail if dimensions do not meet criteria. 1. Review of Resident #9's face sheet (brief information sheet about the resident) showed the following:-admitted on [DATE];-Diagnoses included: schizophrenia (chronic, severe brain disorder that causes individuals to interpret reality abnormally, leading to hallucinations, delusions, and disorganized thinking or behavior), severe intellectual disabilities (reduced cognitive capacity), muscle weakness, discogenic back pain (dull, deep ache in the spine, often in the lower back or neck, that worsens with sitting, bending, coughing, or sneezing, but improves with lying down or extending the spine);-His/her own responsible party. Review showed a bed rail assessment signed by the resident on 11/17/25. Review of the resident's Physician Order Sheet (POS), current as of 02/24/26, showed an order, dated 11/19/25, may have enabler bars to enhance independence with bed mobility. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 01/26/26, showed the following:-Cognitively intact;-Use of wheelchair;-Substantial to maximal assistance for toileting hygiene, showering;-Partial to moderate assistance with personal hygiene;-Dependent on staff for showering;-Bed rail not used as a restraint in bed. Review of the resident's care plan, last reviewed on 11/19/25, showed the following:-Resident had enabler bars to assist with independence in repositioning while in bed Review of the resident and facility records showed staff did not provide documentation of initial or periodic assessments and measurements of the rails to ensure they were placed appropriately and maintained. During an interview and observation on 02/17/26, at 3:00 P.M., showed the following;-Bilateral grab bars in the upright position on the resident's bed;-The resident said he/she used the grab bars to help with repositioning in bed. Observation on 02/19/26, at 1:20 P.M., showed the following;-Bilateral grab bars in the upright position on the resident's bed. Observation on 02/24/26, at 12:45 P.M., showed the following;-Bilateral grab bars in the upright position on the resident's bed. 2. Review of Resident #18's face sheet showed the following:-admitted [DATE];-Diagnoses included: personal history of traumatic brain injury (brain injury that is caused by an outside force), cerebellar ataxia (neurological condition caused by damage or dysfunction in 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	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

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 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cerebellum-the brain's movement control center-leading to a loss of full control of bodily movements), dysphagia (difficulty swallowing), history of falling;-Resident was not his/her own responsible party. Review showed a bed rail assessment signed by the resident on 11/17/25. Review of the resident's POS, current as of 02/24/26, showed an order, dated 11/18/25, for enabler bars to enhance independence with bed mobility. Review of the resident's comprehensive MDS, dated [DATE], showed the following:-Cognitively intact;-Use of wheelchair;-Dependent on staff for toileting hygiene, showering;-Substantial to maximal assistance of staff for dressing, personal hygiene;-Bed rail not used as a restraint while in bed. Review of the resident's care plan, last reviewed on 01/16/26, showed the following:-Resident used enabler bars on the bed to assist with independence in repositioning while in bed. Review of the resident and facility records showed staff did not provide documentation of initial or periodic assessments and measurements of the rails to ensure they were placed appropriately and were maintained or in good repair. During observation and interview on 02/17/26, at 3:25 P.M., the resident said he/she used the grab bar to assist with repositioning in bed. Observation on 02/18/26, at 10:00 A.M., showed the following;-Grab bars in the upright position on the resident's bed.Observation on 02/20/26, at 1:15 P.M., showed the following;-Grab bars in the upright position on the resident's bed. 3. During an interview on 02/23/26, at 11:30 A.M., RN B said there was an assessment form that nursing staff completes and has the resident sign for consent, then staff would request a physician order for the side rails. Once the assessment and physician's order were in place, the nursing staff notify maintenance staff for installation. He/she did not know if there were measurements of the bed rails. 4. During an interview on 02/23/26, at 11:35 A.M., LPN A said once the nurses have the information for a side rail or grab bar, they should complete an assessment and obtain a physician's order, as well as resident or family consent. Once ready for a side rail, nursing staff should notify maintenance for installation. He/she did not know if the maintenance staff had measurements of the side rails and mattress. During an interview on 02/23/26, at 12:45 P.M., Maintenance Director said: -When staff notify him of a bed rail request, there should be a physician's order and nurse or therapy evaluation completed;-He was recently told of the new corporation policy and given the form that contains measurements;-He had no measurements of any side rails in the building at this time;-Up until August 2025 he had been completing safety checks but no measurements and has since not been checking the monthly forms;-He was responsible for the installation of bed rails;-He did not measure the resident beds before he installed the bed rails;-He did not do entrapment assessments;-He did not have ongoing inspection process for measuring the bed frame, mattress, and bed rails, to identify areas of possible entrapment.During an interview on 02/24/26, at 2:00 P.M., the DON said the nursing staff should complete a side rail assessment and obtain resident or family consent for use of side rails. The maintenance staff would then install the bed rails and bed rail entrapment measurements should be updated at least quarterly with the care plan review. During an interview on 02/24/26, at 3:20 P.M., Administrator said that side rail and mattress measurements should be done when installing side rails and should be monitored every month or if changing out a mattress. He said the staff should use the gap measurements form.

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

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 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, 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 (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

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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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.

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

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to provide pharmaceutical services in a manner to ensure the proper storage, destruction, and accountability of medications when the facility did not have a process in place for timely destruction and tracking of the unused medications. A sample of 11 residents' (Resident # 60, #40, #53, #100, #101, #102, #1, #10, #13, #39, #103) medications were located in the medication room waiting to be destroyed. The facility census was 69. Review of the facility policy, dated [DATE], titled Medication Destruction and Diversion Prevention Policy, showed the following:-To ensure safe, secure, and compliant destruction of discontinued, expired, or unusedmedications in accordance with Missouri regulations, Drug Enforcement Administration (DEA) rules, and Center for Medicare and Medicaid Services (CMS) requirements;-For Non-Controlled Medication Destruction Procedure:-Licensed nurse verifies discontinuation or expiration;-Place medication into drug buster container (uses activated charcoal to quickly neutralize the active ingredients of medications);-Document destruction in ledger;-Documentation Requirements;-All entries must include: Date and time, Resident Name, medication name and strength, quantity destroyed, reason for destruction, and signature and two signatures for controlled substances;-Records of destruction must be maintained for a minimum of two years and be readilyretrievable for inspection by Missouri Department of Health & Senior Services (DHSS) and other authorized agencies. During an interview with Certified Medication Technician (CMT) C and observation of the medication room on [DATE] at 12:00 P.M., showed the following:-One cardboard box, approximately 18 by 18 inches in size, located under the sink that was full of unused medication cards, bags, and liquids;-Three grocery style brown bags of unused medications located under the sink;-CMT C said that he/she had disposed of medications on the Sundays that he/she worked. He/she no longer worked on Sundays;-He/she said that he/she helped another CMT dispose of unused medications at least once in the last six months;-He/she said they do not write any information about the unused medications in any logbook but there were cameras in the medication room;-Review showed some medication dispense dates of [DATE], [DATE], and [DATE] on the top of the pile. During an interview with the Director of Nurses (DON) and observation of the medication room on [DATE] at 1:20 P.M., showed the following:-The DON removed the cardboard box and three brown bags from under the sink and pulled medications out of the box and bags;-The DON said the CMT staff should destroy non-narcotic medications at least once per week;-Each medication should be logged before being destroyed and destroyed in drug buster liquid;-She was unaware of the amount to be destroyed in the medication room;-The CMTs were responsible for the medication room;-Review of a small sample of medications pending destruction included the following:-Resident #60, Solu-Medrol injectable 12 mg (steroid that prevents the release of substances in the body that cause inflammation), dispensed [DATE];-Resident # 40, Meropenem 1gm vial (broad-spectrum antibiotic to treat severe bacterial infections), three vials, dispensed [DATE]; Apixaban 2.5 mg (blood thinner used to prevent and treat blood clots), four tablets, dispensed [DATE]; Meclizine 25 mg (used to prevent motion sickness, nausea, vomiting), Omeprazole 40 mg (used to treat acid reflux), and vitamin B complex with vitamin C, four tablets each, dispensed [DATE];-Facility stock dose of Warfarin 1 mg (prescription blood thinner that prevent harmful clots from forming or growing), three tablets, expired [DATE];-Resident #53, Gentamicin 100 mg vial (broad-spectrum antibiotic to treat severe systemic infections), one vial, dispensed [DATE];-Resident #100, Augmentin 875/125 mg (commonly prescribed antibiotic to treat various bacterial infections), 25 tablets, dispensed [DATE]; Trazadone 100mg (prescription to treat depression, anxiety, and insomnia), Duloxetine 60 mg (used to treat depression, anxiety, and chronic pain), Pantoprazole 40 mg (used to treat acid reflux), Losartan 50 mg (used to treat high blood pressure), Gabpentin 600 mg (used to treat nerve pain and manage some (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

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	types of seizures), and Spironolactone 25 mg (treats high blood pressure and heart failure), two tablets each, dispensed [DATE];-Resident #101, Nitroglycerin 4 mg (used to treat chest pain), one vial, dispensed [DATE];-Resident #102, Ceftriaxone 1 gm vial (antibiotic used to treat severe bacterial infections), one vial, dispensed [DATE]; Nafcillin 2 gram, three vials with Sodium Chloride 0.9% IV reconstitution (antibiotic to treat moderate to severe infections), dispensed [DATE];-Resident #1, Gabapentin 100 mg, Eliquis (brand name of Apixaban) 5 mg, Mirtazapine 15 mg (used to treat depression), one tablet each, dispensed on [DATE];-Resident #10, Metronidazole 500 mg (used to treat wide range of infections), seven tablets, dispensed [DATE];-Resident #13, Omeprazole 40 mg tablet, dispensed [DATE];-Resident #39, Spironolactone 25mg, one tablet, dispensed [DATE];-Resident #103, Atorvastatin 40mg (used to treat high cholesterol), Carvedilol 6.25 mg (used to treat high blood pressure and chronic heart failure), Eliquis 5 mg, Sertraline 25mg (used to treat depression), one tablet each, dispensed [DATE]; During an interview on [DATE] at 2:05 P.M., the Administrator said he expects staff to dispose of medication according to pharmacy policy. The DON was responsible for the medication room. He expects unused medications to be destroyed in a timely manner. During an interview on [DATE] at 3:20 P.M., Licensed Practical Nurse (LPN) D said there was not a process for disposal of non-narcotic medications. He/she had never written any information in a logbook for destroyed non-narcotic medications. The narcotics were disposed of by the DON and a nurse and logged on the narcotic disposition sheet. During an observation and interview on [DATE] at 9:15 A.M., CMT E prepared medication for Resident #64. The resident refused the medication. The CMT took the cup of medication to the medication room and removed the drug buster liquid from under the sink and placed Tylenol 500 mg, 2 tablets, and magnesium oxide 400 mg, 1 tablet into the liquid. The CMT said he/she would notify the nurse that the resident refused. He/she did not log this information and said there was no logbook for destroyed medications.

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

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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview, and record review, the facility failed to ensure the nutritional needs of all residents were met when staff failed to prepare pureed diets per approved recipes and failed to provide the approved serving size for pureed meals. The facility census was 69.Review of the facility policy titled, Pureed, revised 10/01/25, showed the following:-Pureed diet menus follow the foods on the regular menu as closely as possible and differ primarily in consistency;-Use an appropriate recipe;-Always refer to the recipe and spreadsheet for directions.Review of the facility's recipe for pureed beef stew showed the following:-Prepare according to the regular beef stew recipe;-Place the number of servings needed, from the regularly prepared recipe into the food processor;-Blend until smooth and serve two #8 scoops (four ounces (oz) per serving.Review of the facility's recipe for beef stew showed the following:-Add oil to large stockpot or saucepan or steam jacketed kettle. [NAME] meat in oil;-Add vegetables, Worcestershire sauce, half of the salt and pepper, water, and base. Bring to a simmer and cook until all ingredients are fork-tender and desired end temperature is reached;-Adjust seasoning with salt and pepper. Serve with a 6 oz spoodle (combination spoon/ladle). Observation on 02/20/26 at 10:29 A.M., showed the following:-Dietary [NAME] (DC) F began to puree the lunch meal for four puree diets;-DC F used four oz scoops to place four servings of beef stew into the processor (the recipe called for 6 ounces of beef stew per serving);-DC F said he/she did not consult a recipe during the puree process.Observation on 02/20/26 at 11:46 A.M., showed the following:-DC F used one four-ounce scoop for serving one pureed portion of beef stew.During an interview on 02/20/26 at 1:24 P.M., DC F said the following:-He/she has not been trained to prepare purees;-He/she does not consult the menu or recipe for serving sizes for puree or serve out;-He/she refers to the Dietary Manager (DM) about correct serving sizes as needed;-He/she does not prepare extra puree meals.During an interview on 02/20/26 at 2:43 P.M., the DM said the following:-Staff should use the recipe book to guide portions for puree preparation and serve out;-He has not been able to train DC F on preparing purees correctly or utilizing the recipe for correct servings;-Staff do not typically make extra puree meals. During an interview on 02/23/26 at 4:38 P.M., the Administrator said staff should follow the recipe/menu for puree meal preparation and serve out.During an interview on 02/24/26 at 8:03 A.M., the Registered Dietician (RD) said staff are expected to follow the portion size indicated on the spread sheet and menus for food preparation and serve out.

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

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, the facility failed to appropriately store and label food items, failed to discard food items when appropriate per labeling, failed to air dry dishes before stacking, and failed to check dishwasher temperatures, all to ensure proper sanitaiton and food handling practices to prevent contamination. The facility census was 69.1. Review of the 2022 Missouri Food Code showed food shall be protected from contamination by storing the food in a clean, dry location and where it is not exposed to splash, dust, or other contamination.Review of the facility policy titled, Food Storage (Dry, Refrigerated, and Frozen), dated 2020, showed the following:-Food shall be stored on shelves in a clean, dry area free from contaminants;-All food items will be labeled. The label must include the name of the food and the date by which it should be sold, consumed, or discarded;-Discard food that has passed the expiration date, and discard food that has been prepared in the facility after seven days of storing under proper refrigeration;-Leftover contents of cans and prepared food will be stored in covered, labeled, and dated containers in refrigerators and/or freezers.Observation on 02/17/26 at 10:45 A.M., showed the following:-A 16-ounce (oz) box of corn starch in the dry storage area, open to air and not labeled with a date;-Inside the walk-in freezer, a large plastic bag of beef patties inside a box, a large plastic bag of waffles inside a box, and a large plastic bag of broccoli inside a box, with all of the plastic bags containing these food items open to air, exposing the food to possible contamination. During an interview on 02/20/26 at 1:24 P.M., Dietary [NAME] (DC) F said all stored food should be sealed and labeled with the date opened and use by date. No food should be open to air.During an interview on 02/20/26 at 2:05 P.M., Dietary Aide (DA) G said all stored food should be sealed, labeled with the date opened and stored in the correct place.During an interview on 02/20/26 at 2:43 P.M., the Dietary Manager (DM) said all stored food should be sealed in a proper container and labeled with the open and use by date.During an interview on 02/23/26 at 4:38 P.M., the Administrator said all stored food should be sealed and labeled with the date opened and the use by date.During an interview on 02/24/26 at 8:03 A.M., the Registered Dietician (RD) said all stored food should be sealed and dated. 2. Review of the US Food and Drug Administration policy, under the section of Food Labeling and Handling, updated 03/04/23, showed the following:-Facility staff must ensure their proper storage, keeping track of when to discard perishable foods, and covering, labeling, and dating all foods stored in the refrigerator or freezer as indicated;-Labeling, dating, and monitoring refrigerated food, including, but not limited to leftovers, so it is used by its use by date, or frozen (where applicable), or discarded.Review of the facility policy titled, Food Storage (Dry, Refrigerated, and Frozen), dated 2020, showed the following:-All food items will be labeled. The label must include the name of the food and the date by which it should be sold, consumed, or discarded;-Discard food that has passed the expiration date, and discard food that has been prepared in the facility after seven days of storing under proper refrigeration;-Leftover contents of cans and prepared food will be stored in covered, labeled, and dated containers in refrigerators and/or freezers.Observation of the dry food storage area on 02/17/26 at 10:45 A.M., showed the following:-A 128 oz container of soy sauce, almost empty, with a date of 05/27/24 written on the container;-A large black plastic bin about one-third full of pinto beans. Beans was written on the container with no dates;-A large black plastic bin about half full of rice. The label had a date of 01/07/25 and use by 06/07/25.During an interview on 02/20/26 at 1:24 P.M., DC F said all food that is past the use by date or expired date should be thrown out.During an interview on 02/20/26 at 2:43 P.M., the DM said all stored food should be thrown out after its use by date.During an interview on 02/23/26 at 4:38 P.M., the Administrator said expired food should be thrown out.During an interview on 02/24/26 at 8:03 A.M., the RD said no food should be available past its use by date.3. Review of the 2022 Missouri Food Code showed dishes are required to be air dried before being stacked and stored.Review of the facility policy titled, Dishes and Utensils, revised 06/19/25, showed dishes, (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

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	trays, and utensils shall be air dried before storage. Observation on 02/17/26 at 10:45 A.M., showed blue coffee cups and plastic bowls stored upside down and ready for use with water sitting in the bottom of the cups and bowls. Small plastic drinking cups were stacked and ready for use with visible water inside the cups. Observation and interview on 02/20/26 at 10:44 A.M., showed the following:-Small, stacked plastic cups ready for use contained water on the inside and on the bottom of the cups;-DA G said the cups had been sitting for a while before they were stacked, but there is not enough time for them to dry completely between breakfast and lunch serve out;-DA G said staff should not stack cups wet, but the facility does not have enough cups and must use the ones not yet dry for lunch.During an interview on 02/20/26 at 1:24 P.M., DC F said dishes should be air dried and not stacked while still wet.During an interview on 02/20/26 at 2:43 P.M., the DM said all dishes should be air dried before stacking.During an interview on 02/23/26 at 4:38 P.M., the Administrator said dishes should not be stacked while wet. They should be allowed to dry before they are stacked.During an interview on 02/24/26 at 8:03 A.M., the RD said dishes should be stacked inverted and only after they have dried.4. Review of the facility policy titled Dishwashing: Machine Operation, dated 2020, showed the following:-The dining services staff shall maintain the operation of the dishwashing machine according to established procedure and manufacturer guidelines posted or contained in this guideline to ensure effective cleaning and sanitizing of all tableware and equipment used in the preparation and service of food;-All dishwashing machines should be operated according to the manufacturer recommendations. Tableware, utensils, and pots and pans should be cleaned and sanitized in either a high-temperature dishwashing machine that uses hot water, or a chemical-sanitizing dishwashing machine that uses chemical sanitizing solutions;-Check the dishwashing machine before first use. If the dishwashing machine has not been used for several hours; it is generally recommended to allow the dishwashing machine to cycle for one or two cycles to allow dishwashing machine to come up to proper function;-Record log documents twice daily for either final rinse temperature or sanitizer concentration;-If the machine is found to be out of the acceptable range for either final rinse temperature or proper chemical sanitizing concentration, do not proceed to wash dishes. Empty dish washing machine, check nozzles and empty bottom screen and restart the dishwashing machine;-After troubleshooting, if the dishwashing machine is not functioning, then employees should contact the DM or maintenance or outside vendor per facility guidelines to coordinate repair period, the dishwashing machine should be labeled out of a service and not utilized until the dishwashing machine is repaired;-If the dishwashing machine cannot be repaired in a timely manner, the facility will utilize the manual dishwashing procedure. Paper goods may be used as a temporary measure until the dishwashing machine was repaired.Review of the Ecolab ELT dishwashing machine specifications showed the Minimum operating temperature for wash is 120 (degrees) and for sanitizing rinse is 120 .Review of the facility's dish machine log showed staff documented the sanitation parts per million (PPM-indicates one part of solution per million parts of entire mixture) two times daily in the A.M. and the P.M. Staff did not document the temperature of the machine cycles.Observation and interview on 02/20/26, at 2:05 PM and 2:17 P.M., showed the following:- Dietary Aide (DA) G put dishes through the dishwasher. The wash cycle temperature was 115 and the rinse cycle was 144 ;-DA G said as of November of last year, staff do not log dishwasher temperatures, only the sanitizer test strip results;-DA G put dishes through another cycle and the wash temperature was 103 and the rinse temperature was 136 .During an interview on 02/20/26 at 2:43 P.M., the DM said the following:-Staff should be logging the wash and rinse cycle temperatures for the dishwasher at every meal service;-He was not sure why staff did not log the temperatures. He should be auditing the logs but had not had time;-The dishwasher wash and rinse cycles should temp at a minimum of 120 .During an interview on 02/23/26 at 4:38 P.M., the Administrator said staff should follow the manufacturer recommendations for dishwasher temperatures and log temperatures and sanitizer testing for each meal service.During an interview on 02/24/26 at 8:03 A.M., the RD said the following:-Staff should be logging dishwasher temperatures at every meal service;-Low temperature dishwashers should temp at 120 for wash and for rinse cycles.