STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265565	A. Building B. Wing	06/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire Senior Living Pleasant Hill	1300 Broadway Pleasant Hill, MO 64080

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the responsible party for one sampled resident (Resident #3) when on 6/4/26 the resident had a fall with significant bruising and pain that resulted in being transported to the hospital for evaluation out of 3 sampled residents. The facility census was 80 residents.Review of the facility's Notification of Changes Policy dated 10/1/25 showed:-The purpose of the policy was to ensure the facility promptly informed the resident, consulted the residence physician, and notified, consistent with his or her authority, the resident's representative when there was a change requiring notification.-The facility must inform the resident, consult with the resident's physician and or notify the residents family member or legal representative when there was a change requiring such notification.-Circumstances requiring notification included accidents that resulted in injury and had potential to require physician intervention. Review of the facility's Fall Prevention Program Policy dated 10/1/25 showed when a resident experienced a fall the facility would notify the physician and the family. 1. Review of Resident #3's admission Record showed he/she was admitted to the facility on [DATE] with the following diagnoses:-Vascular Dementia (changes to memory, thinking, and behavior resulting from conditions that affect the blood vessels in the brain).-Osteoporosis (a disease that weakens your bones and makes them much more likely to fracture). Review of the resident's Quarterly Minimum Data Set (MDS-a federally mandated assessment instrument completed by facility staff for care planning), dated 4/6/26, showed he/she had severe cognitive impairment. Review of the resident's Care Plan revised 1/26/26 showed:-He/She was dependent on staff for meeting emotional, intellectual, physical, and social needs related to cognitive deficits.-He/She had impaired cognitive function related to Dementia.-Interventions included communication with the resident/family/caregivers regarding the resident's capabilities and needs. Review of the resident's General Durable Power of Attorney (DPOA-a legal document that gives one person (such as a spouse, relative, friend, or lawyer) the authority to make medical, legal, or financial decisions for another) dated 6/23/23 showed the resident had a legal DPOA in place and active. Review of the resident's Incident Note dated 6/4/26 at 10:35 A.M., showed:-The hospice (end of life care) aide arrived at the facility to assist the resident with his/her bath and noticed the resident complaining of pain all over. -The hospice aide observed the resident had bruising to left side of his/her head. -The resident was wincing, arched forward, and crying out in pain. -The hospice nurse and the resident's DPOA were contacted by the hospice aide.-The hospice nurse and daughter requested that the resident be sent out to the hospital for evaluation and treatment.-Emergency medical Services (EMS) was called at 10:55 A.M.-EMS arrived at the facility and transferred the resident to the hospital at 11:10 A.M. During an interview on 6/9/26 at 2:30 P.M., Registered Nurse (RN) A said:-He/She was the nurse on duty when it was brought to his/her attention by the hospice aide that the resident had injuries from a fall the previous night. -He/She was told in the morning report on 6/4/26 by the night shift nurse that the resident had a non-injury fall during the previous night shift.-He/She was not told the time that the resident fell during the night shift.-He/She did not contact the resident's DPOA or hospice care team to notify (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	them about the resident's fall. -He/She was not sure if the night nurse contacted the resident's DPOA or hospice care team after the resident fell. -There was no documentation in the resident's chart that the DPOA or hospice care team was notified when the resident fell. -The hospice aide was the one who notified the resident's DPOA and hospice nurse after he/she observed that resident's injuries around 10:00 A.M on 6/4/26.-The resident fell sometime during the night shift on 6/3/26.-The facility policy stated that the nurse on duty when a resident fell was to contact the resident's DPOA and hospice care team to notify them of a resident's fall. -The expectation was that the night nurse should have called the resident's DPOA and hospice care team when the resident fell during the night shift the previous night. During an interview on 6/9/26 at 3:00 P.M., the Hospice Certified Nurse Assistant (CNA) A said:-He/She was visiting residents in the facility on 6/4/26 between 08:00 A.M. and 10:00 A.M.-When he/she went into the resident's room to give the resident a shower, the resident was in bed.-He/She noticed that the resident was moaning, crying, and had very significant bruising on the left side of the head and face.-The resident was screaming out in pain and that was very unusual for the resident. -He/She called the resident's hospice nurse and called the resident's DPOA to notify them of his/her findings. -The resident's DPOA was not aware of the fall when he/she notified them.-The hospice nurse was not aware of the fall when he/she notified them.-The facility did not contact the resident's DPOA or the hospice care team about the resident's fall. -He/She notified the day charge nurse, RN A, that the resident had bruising and was screaming out in pain.-RN A informed him/her that it was reported to him/her that the resident had a non-injury fall during the previous night. -RN A did not appear to be aware that the resident had injuries and was in pain. -Note: Left a voicemail on 6/9/26 at 3:30 P.M., and again on 6/10/26 at 10:00 A.M., for the night nurse who was on duty when the resident fell. As of 6/10/26 at 1:00 P.M., the nurse has not returned the call. During an interview on 6/9/26 at 3:30 P.M. the resident's DPOA said:-He/She was never notified by the facility about the resident's fall.-He/She was notified by the resident's hospice aide several hours after the resident fell.-He/She went to the facility to check on the resident after being notified by the hospice aide about the significant injuries. -The resident had significant injury and should have been sent to the hospital as soon as the fall occurred.-The resident was crying and screaming in pain when he/she arrived at the facility several hours after the fall occurred. -He/She would have requested earlier intervention and pain control for the resident if he/she was contacted at the time of the fall.-He/She was never told the full story of how the fall occurred.-He/She was never told what time the fall occurred during the night shift. -He/She had never spoken to the nurse who was on duty when the resident fell. -His/Her first contact with the facility staff about the resident's fall was when she arrived at the facility after the hospice aide contacted her. -As soon as he/she saw the resident's horrible condition, he/she requested that the resident be sent to the hospital for evaluation and pain control.-It was the policy of the facility to contact him/her when the resident had a fall as he/she has an active DPOA on file for the resident and makes all of the resident's medical decisions.-The resident was unable to speak for himself/herself or communicate needs due to the resident's dementia. During an interview on 6/9/26 at 4:23 P.M., the Interim Director of Nursing (DON) said:-He/She was the interim DON for the facility and acting in place of the Administrator who was currently on vacation. -The DPOA should be notified as soon as possible after a resident has fallen.-It was the expectation that the nurse who was on duty when the resident fell was the nurse who contacted the resident's DPOA, the Administrator, the DON, the physician, and in this case, the hospice care team, after the resident fell.-The notifications should have occurred before the night shift was over and before the nurse left his/her shift.-The night nurse who was working the night that the resident fell was placed on administrative leave for not following the facility policy and will be educated on notification of DPOA policy. During an interview on 610/26 at 11:00 A.M., the Hospice Case Manager RN said :-He/She was not notified of the resident falling until contacted by the hospice aide the morning after the resident fell.-When he/she was notified of the resident's injuries by the aide, he/she called the resident's DPOA and went to the facility to assess the resident.-The facility (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	did not contact the residents' DPOA and notify the DPOA of the resident falling.-The resident had significant injuries and upon assessment, he/she decided that the resident needed to be sent to the emergency room for evaluation and treatment.-When he/she arrived at the facility the resident was screaming in pain and had bruising on the entire side of the left face, head, and neck. -The resident could at baseline move around and help with care but was unable to help at all or move when he/she arrived at the facility. Complaint number: 3037533

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a comprehensive investigation was completed that included details of the circumstances of the fall, failed to complete a fall risk analysis of what occurred to cause the fall, failed to update the care plan and add interventions implemented to prevent the fall from recurring, and failed to complete a post fall assessment and failed to access for injuries for one sampled resident (Resident #3) out of three sampled residents who fell on 6/4/26 sustaining significant pain and bruising to the left side of face, head and neck. The facility census was 56 residents.Review of the facility's Fall Prevention Program policy dated 10/1/25, showed:-Each resident would be assessed for fall risk and would receive care and service in accordance with their individualized level of risk to minimize the likelihood of falls. -A fall risk assessment would be completed every 90 days and as indicated when the resident had a change in condition. -Each resident's risk factors and environmental hazards would be evaluated when developing the resident's comprehensive care plan, monitored for effectiveness, and the plan of care would be revised as needed. -When a resident was at a high risk for falls, the facility would provide interventions that addressed unique risk factors measured by the risk assessment tool. -When a resident experienced a fall, the facility would:--Assess the resident.--Complete a post fall assessment.--Complete an incident report.--Notify physicians and family.--Review the resident's care plan and update as indicated.--Document all assessments and actions.--Obtain witness statements in the case of injury. 1. Review of Resident #3's admission Record showed he/she was admitted to the facility on [DATE] with the following diagnoses:-Chronic Kidney Disease Stage 3 (the kidney's function has been cut by half, and most patients experience ancillary problems like high blood pressure or bone difficulties).-Vascular Dementia (changes to memory, thinking, and behavior resulting from conditions that affect the blood vessels in the brain).-Osteoporosis (a disease that weakens your bones and makes them much more likely to fracture). -Major Depressive Disorder (a mental health condition characterized by persistent feelings of sadness, hopelessness, and a lack of interest or pleasure in activities). Review of the resident's General Durable Power of Attorney (DPOA-a legal document that gives one person (such as a spouse, relative, friend, or lawyer) the authority to make medical, legal, or financial decisions for another) dated 6/23/23 showed the resident had a legal DPOA in place and active. Review of the resident's Care Plan revised 1/26/26 showed:-He/She was dependent on staff for meeting emotional, intellectual, physical, and social needs related to cognitive deficits.-He/She had impaired cognitive function related to Dementia.-He/She had potential for pain related to Osteoporosis.-Interventions for pain control included:--Anticipating the resident's need for pain relief and respond immediately to anycomplaints of pain.--Monitoring and documenting for probable cause of each pain episode. --Removing and limiting the cause of the resident's pain. where possible.-He/She was high risk for falls related to confusion. -The resident would not sustain serious injury from a fall through the review date. -Interventions for high fall risk included:--Communication with the resident/family/caregivers regarding the resident's capabilities and needs.--Anticipating and meeting the residents' needs.--Reviewing information on past falls and attempting to determine the cause of falls.--Recording possible root causes of falls. --Altering and removing any potential causes of falls if possible. --Educating resident/family/caregivers/IDT as to causes of falls.-No updates or interventions were added to the care plan after the resident had a fall on 6/4/26. Review of the resident's Quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning), dated 4/6/26, showed he/she had severe cognitive impairment. Review of the resident's Incident Note dated 6/4/26 at 10:35 A.M., showed:-The hospice (end of life care) aide arrived at the facility to assist the resident with his/her bath and noticed the resident complaining of pain all over. -The (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	hospice aide observed the resident had bruising to left side of his/her head. -The resident was wincing, arched forward, and crying out in pain. -The hospice nurse and the resident's DPOA were contacted by the hospice aide.-The hospice nurse and resident family requested that the resident be sent out to the hospital for evaluation and treatment.-Emergency medical Services (EMS) was called at 10:55 A.M.-EMS arrived at the facility and transferred the resident to the hospital at 11:10 A.M. Review of the resident's electronic medical record (EMR) on 6/9/26 at 10:00 A.M., showed:-No incident report was documented on 6/4/26 after the resident allegedly fell during the night shift.-No post fall assessment was documented on 6/4/26.-No vital signs were documented on 6/4/26. -No nursing evaluation regarding sustained injuries. -No neurological assessments were documented on 6/4/26. -No risk analysis assessment was documented on 6/4/26. Review of the resident's Incident Note dated as a late entry on 6/9/26 at 11:00 A.M., showed the nurse received report from the previous shift nurse that the resident was observed on the floor in his/her bathroom. During an interview on 6/9/26 at 2:30 P.M., Registered Nurse (RN) A said:-He/She was the day shift nurse on duty when it was brought to his/her attention by the hospice aide that the resident had injuries from a fall the previous night. -He/She was told in the morning report on 6/4/26 by the night shift nurse that the resident had a non-injury fall during the previous night shift.-He/She was not told the time that the resident fell during the night shift.-He/She did not contact the resident's DPOA or hospice care team to notify them about the resident's fall. -He/She was not sure if the night nurse contacted the resident's DPOA or hospice care team after the resident fell. -There was no documentation in the resident's chart that the DPOA or hospice care team was notified when the resident fell. -The hospice aide was the one who notified the resident's DPOA and hospice nurse after he/she observed that resident's injuries around 10:00 A.M on 6/4/26.-The resident fell sometime during the night shift on 6/3/26.-He/She was not monitoring the resident's vital signs after the fall due to being told that it was a non-injury fall by the off going nurse.-He/She was not performing neurological assessments on the resident's after the fall due to being told that it was a non-injury fall from the off going nurse.-He/She did not assess the resident until hours after the fall when the hospice aide brought the injuries to his/her attention.-He/She was unsure of the previous night nurse assessed the resident after the fall.-There was no documentation in the resident's chart to support a post fall assessment that was completed from the previous night shift nurse.-He/She did not complete an incident report on the fall with details of the fall.-The previous nurse did not complete an incident report on the fall with details of the fall. -He/She did not update the resident's care plan with new interventions after the fall.-The night shift nurse did not update the resident's care plan with new interventions after the resident fell.-He/She was not sure if there were any witnesses to the fall.-The night shift nurse did not provide witness statements for the fall or share if there were any witnesses.-There was nothing documented in the resident's medical record from the nurse who was on duty when the fall occurred at all.-It would have been expected that the nurse that was on duty when the resident fell to follow the fall policy and document everything that was done pertaining to the fall. -There was no investigation completed into the resident's fall.-A fall investigation should have been started and completed by the night nurse that was on duty when the resident fell. During an interview on 6/9/26 at 3:00 P.M., the Hospice Certified Nurse Assistant (CNA) A said:-He/She was visiting residents in the facility on 6/4/26 between 08:00 A.M. and 10:00 A.M.-When he/she went into the resident's room to give the resident a shower, the resident was in bed.-He/She noticed that the resident was moaning, crying, and had very significant bruising on the left side of the head and face.-The resident was screaming out in pain and that was very unusual for the resident. -He/She called the resident's hospice nurse and called the resident's DPOA to notify them of his/her findings. -He/She notified the day charge nurse, RN A, that the resident had bruising and was screaming out in pain.-RN A informed him/her that it was reported to him/her that the resident had a non-injury fall during the previous night. -RN A did not appear to be aware that the resident had injuries and was in pain. -No interventions were done to decrease the resident's pain or get the resident evaluated until he/she (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	found the resident hours after the fall, laying in bed crying and with injuries. During an interview on 6/9/26 at 3:30 P.M., the resident's DPOA said:-He/She was notified by the resident's hospice aide several hours after the resident fell.-He/She went to the facility to check on the resident after being notified by the hospice aide about the significant injuries. -The resident had significant injury and should have been sent to the hospital as soon as the fall occurred.-The resident was crying and screaming in pain when he/she arrived at the facility several hours after the fall occurred. -He/She would have requested earlier intervention and pain control for the resident if he/she was contacted at the time of the fall.-He/She was never told the full story of how the fall occurred.-The resident was not assessed after he/she fell.-He/She was told by the hospice care team that the fall was never investigated by the facility. -As soon as he/she saw the resident's horrible condition, he/she requested that the resident be sent to the hospital for evaluation and pain control.-The facility did not assess the resident properly after the resident fell.-The facility could not provide any evidence that vitals were assessed after the resident fell.-The facility could not provide any evidence that neurological assessments were completed on the resident after the resident fell.-The resident must have hit his/her head when falling as evidence by the significant bruising to his/her head, neck and face.-The facility knew that the resident was a fall risk.-The resident was unable to speak for himself/herself or communicate needs due to the resident's dementia. During an interview on 6/9/26 at 4:23 P.M., the Interim Director of Nursing (DON) said:-He/She was the interim DON for the facility and acting in place of the Administrator who was currently on vacation. -It was the expectation that the nurse who was on duty when the resident fell was the nurse who contacted the resident's DPOA, the Administrator, the DON, the physician, and in this case, the hospice care team, after the resident fell.-The notifications should have occurred before the night shift was over and before the nurse left his/her shift.-The facility did not complete a fall investigation on the fall.-The nurse did not document a neurological assessment on the resident after the fall.-The nurse did not complete a risk analysis after the resident fell.-The nurse did not document vital signs or post fall assessment after the resident fell. -The nurse did not update the residents care plan with new interventions after the reident fell.-It was the expectation that the nurse followed the fall policy after the resident fell.-After the resident fell, the nurse should have assessed the resident, obtained vitals, started a neurological assessment, completed an incident report, completed a risk analysis, contacted the DPOA, DON, administrator and physician.-The nurse should have started and completed a fall investigation after the resident fell.-The nurse should have updated the resident's care plan after the resident fell.-The nurse did not follow the facility policy in handling the resident's fall. -The night nurse who was working the night that the resident fell was placed on administrative leave for not following the facility policy and will be educated on the policies and procedures. During an interview on 610/26 at 11:00 A.M., the Hospice Case Manager RN said:-He/She was not notified of the resident falling until contacted by the hospice aide the morning after the resident fell.-When he/she was notified of the resident's injuries by the aide, he/she called the resident's DPOA and went to the facility to assess the resident.-The resident had significant injuries and upon assessment, he/she decided that the resident needed to be sent to the emergency room for evaluation and treatment.-When he/she arrived at the facility the resident was screaming in pain and had bruising on the entire side of the left face, head, and neck. -The resident could at baseline move around and help with care but was unable to help at all or move when he/she arrived at the facility. -The facility did not perform neurological assessments on the resident after the fall.-It was apparent and obvious that the resident hit his/her head when falling.-This situation could have potentially been life threatening with major injuries and proper nursing assessments were not conducted by the facility to ensure that resident's safety after the resident fell. Complaint number: 3037533