STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265157	A. Building B. Wing	04/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Springfield Rehabilitation & Health Care Center	2800 South Fort Avenue Springfield, MO 65807

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 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on interview and record review, the facility failed to complete the annual individual performance reviews or evaluations and failed to provide regular in-service education based on these reviews for three certified nurse aides (Certified Nurse Aide (CNA) K, CNA L, and CNA M), out of a sample of six CNAs. The facility census was 117.Review showed the facility did not provide a policy regarding annual individual performance reviews or education for CNAs.1. Review of CNA K's personnel records showed the following:-Hire date of 04/10/24;-Annual performance evaluation due on 04/10/25; -Staff did not document completion of the performance evaluation or education provided to CNA K based on an annual performance evaluation.2. Review of CNA L's personnel records showed the following:-Hire date of 08/22/23;-Annual performance evaluation due on 08/22/25;-Staff did not document completion of the performance evaluation or education provided to CNA L based on an annual performance evaluation.3. Review of CNA M's personnel records showed the following:-Hire date of 09/04/20;-Annual performance evaluation due in September 2021, 2022, 2023, 2024, or 2025;-Staff did not document completion of the performance evaluation or education provided to CNA M based on an annual performance evaluation. 4. During an interview on 04/10/26, at 1:26 P.M., CNA O said the following:-He/she had been working at the facility for over a year;-He/she did not receive an annual performance evaluation. During an interview on 04/10/26, at 1:50 P.M., CNA N said the following:-He/she had worked at the facility for approximately 14 months;-He/she did not receive an annual performance evaluation.During interviews on 04/09/26, at 1:05 P.M., and on 04/10/26, at 9:10 A.M. and 2:30 P.M., the Director of Nursing (DON) said the following:-He/She was responsible for completing the annual performance evaluations for the CNA's;-He/She had not been good at completing annual evaluations, so he/she knew some of them had not been done;-He/She did not know the performance appraisals needed to be tracked;-In January of 2025, the facility started using an electronic system to complete annual evaluations, but he/she had not been consistent in completing the CNA annual evaluations;-Prior to the electronic performance appraisal system being implemented, the facility did not have a performance evaluation system in place, not even in paper format;-He/She had only been addressing concerns in person with the CNA's if an issue is identified rather than completing an annual performance appraisal;-He/She did not have time to complete the annual performance appraisals;-The CNA's annual performance evaluations should be completed annually.During an interview on 04/10/26, at 2:30 P.M., the Administrator said the following:-The facility had a new electronic system to complete the annual performance evaluations;-He expected the CNA annual performance evaluations to be completed annually.

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
	265157	A. Building B. Wing	04/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Springfield Rehabilitation & Health Care Center	2800 South Fort Avenue Springfield, MO 65807

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, and record review, the facility failed to ensure all residents were treated with dignity and respect when one staff member (Licensed Practical Nurse (LPN) A) spoke in a disrespectful tone and manner when interacting with one resident (Resident #70) resulting in the resident becoming upset. The facility census was 117. Review of the facility policy titled Patient Rights, undated, showed the following:-The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility.-A facility must protect and promote the rights of each resident. 1. Review of Resident #70's face sheet (a form used to provide resident information at a quick glance) showed the following:-admission date of 09/26/25;-Diagnoses included muscle weakness, age related cognitive decline (a decline on cognitive function due to age), major depressive disorder (a serious mental health condition characterized by at least two weeks of persistent, severe low mood, loss of interest, and low energy), and anxiety disorder (mental health conditions characterized by excessive, persistent, and uncontrollable fear or worry that interferes with daily life). Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 01/02/26, showed the resident was cognitively impaired. Review of the resident's care plan, revised on 04/04/26, showed the following:-Staff should observe for non-verbal symptoms of distress;-Cue to sources of reality orientation as indicated;-Introduce self and role, reorient to room, call light, environment as needed;-Speak clearly and use simple terms, explain procedures prior to beginning. Observation and interview on 04/07/26, at approximately 3:45 P.M., showed the following: -The resident walked with his/her walker near the water/ice cart getting ice in his/her water pitcher;-LPN A approached the ice/water cart and said loudly in a stern voice to the resident you know you are not supposed to get into the ice and water cart;-The resident said, well, there was nobody around to help. The resident said he/she was just getting some ice;-LPN A said you are not allowed to get the ice/water. Staff are to do this. LPN A said he/she was right there at the nurses' station;-The resident became visibly upset and there were other residents sitting near this area;-The resident walked off without his/her walker and water pitcher. The resident had tears in his/her eyes and kept saying he/she didn't do anything wrong and the nurse got onto him/her for no reason;-Registered Nurse (RN) Q followed and walked with the resident to his/her room;-The resident sat in a chair in his/her room and began crying and kept saying he/she didn't deserve that. He/she did not know what he/she did wrong;-LPN A approached the resident's room with the walker and water pitcher and did not say anything to the resident;-The resident then said he/she wanted to use the phone to call his/her family member to come and get him/her;-RN Q gave the resident his/her walker and walked with the resident to the nurses' station to make a call to his/her family member. Observation and interview on 04/07/26, at approximately 4:05 P.M., showed the following: -The resident and RN Q sat in the main dining room where the resident remained visibly upset with tears running down his/her face;-The resident said he/she did not know what he/she did wrong;-RN Q told the resident he/she did not do anything wrong;-The resident said he/she did not want to be in trouble. Tears continued to run down his/her face;-Other residents asked the resident what was wrong. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265157	A. Building B. Wing	04/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Springfield Rehabilitation & Health Care Center	2800 South Fort Avenue Springfield, MO 65807

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 04/07/26, at 4:15 P.M., showed the following: -Resident was tearful with red watery eyes and asked if the surveyor was there to arrest him/her;-The resident wiped his/her eyes with tissue papers trying to dry his/her face from the tears;-He/she said he/she did not know what happened just that he/she was accused of something he/she did not do;-Resident said he/she was scared, thought he/she was in trouble, and thought he/she had done something wrong. During an interview on 04/07/26, at 4:20 P.M., LPN A said the following:-Residents are not supposed to get into the ice and water cart;-He/she got up from the nurses' station after the resident had already filled his/her cup with ice and water;-He/she told the resident to ask for help next time;-The resident said he/she could not find anyone to help him/her;-He/she took the resident's water pitcher to close the lid, and the resident became upset, and walked off without the water or his/her walker;-The resident was very upset;-He/she was trying to redirect the resident;-He/she could have just left it alone, snapped the lid on the resident's water pitcher, and took the cart to the kitchen to be cleaned. During an interview on 04/07/26, at 4:18 P.M., RN Q said the following:-The cart that sat on B-hall was the refreshment cart used to pass ice and water to residents;-If a resident approached the refreshment cart, he/she would offer to get ice and/or water for the resident;-Staff wear gloves when handling the ice scoop;-If a resident had already gotten the ice, like what happened with Resident #70, he/she would not say anything and would sanitize the ice bucket if needed. During an interview on 04/09/26, at 11:23 A.M., Certified Nursing Assistant (CNA) C said the following:-He/she believed yelling at or speaking harshly to a resident should be reported to the Nurse or Director of Nursing (DON):-If a resident was doing something that is dangerous or something he/she should not be doing, the aide would intervene by redirecting the resident or asking if the resident needed help, not by yelling or speaking harshly to the resident. During an interview on 04/09/26, at 11:28 A.M., CNA D said the following:-He/she would use redirection if they saw a resident getting into something;-He/she would ask if they needed help to direct their attention elsewhere;-Yelling or speaking down to a resident not appropriate. During an interview on 04/07/26, at 4:13 P.M., RN P said the following:-The ice/water cart that sits at the end of B-Hall is for the staff to pass to residents;-The staff encourage residents not to get into the ice/water cart due to contamination concerns;-If a resident approaches the ice/water cart, staff will tell the resident to let them get that for the resident;-Staff should not scold residents for getting ice/water from the cart;-The resident was alert and oriented with some confusion and required minimal assistance with care.-The resident gets upset if he/she feels like staff are getting onto him/her. During an interview on 04/07/26, at 4:52 P.M., the resident's family member said the facility notified him/her that someone had gotten on to the resident and he/she was upset. During an interview on 04/10/26, at 11:30 A.M., the Director of Nursing (DON) said the following:-He/she expected all staff to be kind with all residents;-Staff should utilize redirection when approaching residents who may be getting into something;-LPN A was concerned with infection control when he/she was stern with the resident and could have approached the situation differently. During an interview on 04/07/26, at 4:31 P.M., the Administrator said the following:-The water/ice cart was for the residents, and they have several independent residents who used it. -Staff usually (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265157	A. Building B. Wing	04/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Springfield Rehabilitation & Health Care Center	2800 South Fort Avenue Springfield, MO 65807

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	take the cart down the hall and pass water and ice;-If a resident goes to the cart, staff should offer to help them get ice and water.-Staff should never scold a resident;-Staff should have let the resident get his/her ice and water and then if needed clean the ice/water cart.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265157	A. Building B. Wing	04/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Springfield Rehabilitation & Health Care Center	2800 South Fort Avenue Springfield, MO 65807

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, the facility failed to ensure all allegation of possible abuse were reported immediately to facility management and to the Department of Health and Senior Services (DHSS) within the required two hour timeframe when staff one resident's (Resident #76) allegation of physical abuse. The facility census was 117.Review of the facility's policy titled Abuse Protection and Response Policy, showed the following:-Abuse, Neglect, and Misappropriation of Patient Property, as hereafter defined, will not be tolerated by anyone, including staff, patients, consultants, volunteers, family members or legal guardians, friends, visitors, or any other individual in this center;-Any patient event that is reported to any partner by patient, family, other partner or any other person will be considered an allegation of abuse if it meets any of the following criteria: any allegation (or) indication of possible willful infliction of injury to include unexplained bruising; unreasonable confinement to include unwanted restriction of access to all patient areas of the building; any patient or family complaint of physical or verbal harm, pain or mental anguish resulting from the actions of others; any instances of hitting, slapping, pinching, or kicking or other potentially harmful action;-Any partner having either direct or indirect knowledge of any event that might constitute abuse, neglect, or misappropriation of patient property must report the event immediately;-All alleged violations and all substantiated incidents will be reported immediately to the administrator or her/his designated representative and to other officials in accordance with State and Federal law (including to the State survey and certification agency). All allegations and incidents will be reported to the DHSS within two hours.1. Review of Resident #76's face sheet (a document that gives a patient's information at a quick glance) showed the following:-admission date of 03/21/26;-Diagnoses included diverticulitis (inflammation or infection of small pouches (diverticula) that form in the weak spots of the colon wall), heart disease, and anxiety.Review of the resident's admission Minimum Data Set (MDS - a federally mandated comprehensive assessment instrument completed by facility staff,) dated 03/21/26, showed the following:-The resident had severe cognitive impairment;-The resident had no behaviors;-The resident required moderate assistance from staff for upper body dressing and personal hygiene and was dependent on staff to shower, toilet and for lower body dressing;-The resident required moderate to maximum assistance from staff for bed mobility and was dependent on staff to transfer.Review of the resident's care plan, dated 04/03/26, showed the following:-The resident had a cognitive deficit. Allow the resident time to process what was said and give a response. Ask yes or no questions when indicated. Keep all communication simple when the resident was overwhelmed;-The resident had a cognition and communication deficit related to a history of a brain abscess (a life-threatening, pus-filled, and inflamed swelling within the brain tissue, often resulting from bacterial or fungal infections, trauma, or surgery) with residual deficits. The resident was able to make his/her needs known. The resident had a short-term memory problem; -The resident had an activities of daily living (ADL - dressing, eating, bathing, etc.) deficit and required moderate assistance with ADL's related to lower extremity weakness while he/she recovered from diverticulitis. Review of the resident's nurse's progress note dated 03/29/26, at 5:38 P.M., showed Registered Nurse (RN) H documented the following:-The resident received skilled nursing services related to diverticulitis. The resident was cooperative upon approach. The resident had no report of unrelieved pain or discomfort. The resident was alert and oriented to person, place and time. His/her lungs were clear to auscultation (no abnormal breath sounds), respirations were even and unlabored. Staff did not observe a cough and no one reported a cough;-The resident did experience some shortness of breath around 4:00 P.M. The resident said he/she could not breathe and reported being strangled by someone who was in his/her room. Nobody was in the room with the resident at the time;-The resident's SpO2 (oxygen (O2) saturation in the blood) read 75% (normal is over 90%) per the certified nursing assistant (CNA). Staff obtained oxygen and the resident's SpO2 increased to 95% at (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265157	A. Building B. Wing	04/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Springfield Rehabilitation & Health Care Center	2800 South Fort Avenue Springfield, MO 65807

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the time but the resident still demonstrated shortness of breath. Staff applied O2 at one liter using a nasal canula which helped.(The RN did not document reporting the allegation of possible abuse to management or DHSS.)Review of DHSS records showed the facility did not self-report the allegation of possible abuse. During an interview on 04/08/26, at 9:37 A.M., RN H said the following:-On 03/29/26, the resident did allege abuse to him/her;-RN H did not document he/she reported to anyone so he/she cannot say that he/she did for sure;-RN H believed he/she reported the allegation;-The allegation made by the resident should have been reported to DHSS within two hours and law enforcement should have been notified;-He/she should have notified the resident's physician and responsible party;-Types of abuse included physical, emotional, verbal and neglect;-If a resident reported abuse to a CNA or Certified Medication Tech (CMT), they reported it to the charge nurse immediately;-The charge nurse reported to social services immediately and wrote a progress note;-The charge nurse notified the resident's physician and responsible party;-Social services reports it to DHSS; -If a resident reported that someone strangled them, he/she considered that abuse and would report that to social services immediately;-The allegation should be reported to DHSS;-All allegations of abuse were reported. During an interview on 04/08/26, at 9:21 A.M., Licensed Practical Nurse (LPN) G said the following:-The allegation made by the resident should have been passed on to be followed up on;-The way he/she read the nurse's progress note, he/she considered this an allegation of abuse that should have been reported to DHSS;-The resident's mental status should not affect whether the allegation was reported;-Types of abuse included verbal, mental, physical, elder and financial;-If a resident reported abuse to a CNA or a CMT, they immediately reported the allegation to the charge nurse;-The charge nurse immediately reported the allegation to the Director of Nursing (DON);-The DON reported allegations of abuse to DHSS within 24 hours;-The charge nurse assessed the resident and notified the resident's responsible party and physician;-The DON or charge nurse notified law enforcement;-All allegations of abuse were reported to DHSS;-If a resident reported someone strangled them in their room, he/she considered that physical abuse and should be reported to DHSS.During an interview on 04/08/26, at 9:07 A.M., CNA E said the following:-Types of abuse included emotional, physical, verbal, neglect and financial;-If a resident reported abuse to him/her, he/she reported it to the charge nurse immediately;-The charge nurse assessed the resident and reported it to the DON;-The DON reported allegations of abuse to DHSS immediately;-All allegations of abuse were reported;-If a resident reported to him/her that someone strangled them in their room, he/she considered this abuse and would report this immediately and the facility would be required to report the allegation to DHSS.During an interview on 04/08/26, at 9:14 A.M., CNA F said the following:-Types of abuse included misappropriation, neglect, sexual, verbal, mental and physical;-If a resident reported abuse to him/her, he/she reported it to the charge nurse immediately;-The charge nurse filled out an abuse report and sent the report to the DON;-The charge nurse, Assistant Director of Nursing (ADON), DON, or Administrator reported it to DHSS within two hours;-If a resident reported to him/her that someone strangled them in their room, he/she considered this an allegation of physical abuse and reported the allegation;-The facility should report the allegation to DHSS;-The facility should report all allegations of abuse to DHSS.During an interview on 04/09/26, at 4:56 A.M., RN I said the following:-Types of abuse included physical, neglect, mental, psychological, verbal, sexual and financial;-If a resident reported abuse to a CNA or CMT, they reported it to the charge nurse immediately;-The charge nurse reported it to the DON or supervisor in the building immediately;-The charge nurse, supervisor or DON reported it to DHSS immediately after they ensured the resident was safe;-The charge nurse notified the resident's responsible party and physician;-If a resident reported someone strangled them in their room, he/she considered that an allegation of physical abuse and reported that immediately to the Administrator and DHSS.During an interview on 04/10/26, at 9:57 A.M., CMT J said the following:-Types of abuse included verbal, physical, sexual, neglect and financial;-If a resident reported abuse to him/her, he/she immediately reported it to the charge nurse and if the report was about the charge nurse, he/she reported it to the ADON 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
	265157	A. Building B. Wing	04/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Springfield Rehabilitation & Health Care Center	2800 South Fort Avenue Springfield, MO 65807

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	DON;-The charge nurse reported it to the DON immediately;-The DON or Administrator reported it to DHSS within two hours;-All allegations of abuse were reported to DHSS even if the resident who made the allegation had dementia;-If a resident reported someone strangled them in their room, he/she considered this an allegation of physical abuse and would report it immediately;-If a resident made that allegation, the allegation should have been reported to DHSS.During an interview on 04/10/26, at 2:13 P.M., the DON said the following:-He/she expected staff to immediately report all allegations of abuse after they ensured the resident was safe;-RN H did not report the allegation made by the resident to her;-If a resident reported someone strangled them he/she considered this an allegation of abuse and should be reported to DHSS within two hours;-Staff should notify the resident's physician and responsible party if a resident made an allegation of abuse;-All allegations of abuse have to be reported to DHSS.During interviews on 04/08/26, at 9:55 A.M., and on 04/10/26, at 2:13 P.M., the Administrator said the following:-If someone was in the resident's room when the resident made the allegation of being strangled, he/she would consider it an allegation of abuse;-The resident had severe cognitive impairment;-The allegation was not reported to him;-The leadership team was responsible for ensuring staff knew when to report allegations of abuse;-He expected staff to report allegations of abuse immediately and was responsible for ensuring allegations of abuse were reported to DHSS.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265157	A. Building B. Wing	04/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Springfield Rehabilitation & Health Care Center	2800 South Fort Avenue Springfield, MO 65807

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interview and record review, the facility failed to ensure all allegations of abuse were investigate when staff failed to complete an investigation of an allegation of physical abuse made by one resident (Resident #76). The facility census was 117.Review of the facility's policy titled Abuse Protection and Response Policy, undated, showed the following:-Abuse, Neglect, and Misappropriation of Patient Property, as hereafter defined, will not be tolerated by anyone, including staff, patients, consultants, volunteers, family members or legal guardians, friends, visitors, or any other individual in this center;-All events reported as possible abuse, neglect, or misappropriation of patient property will be investigated to determine whether the alleged abuse, neglect, or misappropriation of patient property did or did not take place. The Administrator or Director of Nurses (DON) will determine the direction of the investigation once notified of alleged incident;-The investigation is conducted immediately under the following circumstances: when it is identified that an alleged incident may have occurred and as soon as any partner has knowledge and reports an alleged event;-When there is question as to whether to conduct an investigation, it is best to do so;-The results of all investigations will be completed within five working days of the incident. Depending on the result of the investigation all necessary corrective actions will be taken;-Allegations of abuse, neglect, or misappropriation of patient property will trigger an internal investigation following the protocol of the Untoward Events Policy and Procedure;-Trends of investigative findings will be analyzed and addressed by the Quality Improvement (QI) committee process.1. Review of Resident #76's face sheet (a document that gives a patient's information at a quick glance), showed the following:-admission date of 03/21/26;-Diagnoses included diverticulitis (inflammation or infection of small pouches (diverticula) that form in the weak spots of the colon wall), heart disease, and anxiety.Review of the resident's admission Minimum Data Set (MDS - a federally mandated comprehensive assessment instrument completed by facility staff), dated 03/21/26, showed the following:-The resident had severe cognitive impairment;-The resident had no behaviors;-The resident required moderate assistance from staff for upper body dressing and personal hygiene and was dependent on staff to shower, toilet and for lower body dressing;-The resident required moderate to maximum assistance from staff for bed mobility and was dependent on staff to transfer.Review of the resident's care plan, dated 04/03/26, showed the following:-The resident had a cognitive deficit. Allow the resident time to process what was said and give a response. Ask yes or no questions when indicated. Keep all communication simple when the resident is overwhelmed;-The resident had a cognition and communication deficit related to a history of a brain abscess (a life-threatening, pus-filled, and inflamed swelling within the brain tissue, often resulting from bacterial or fungal infections, trauma, or surgery) with residual deficits. The resident was able to make his/her needs known. The resident had a short-term memory problem. Staff should introduce self and role, reorient the resident to his/her room, call light and environment as needed. Speak clearly and use simple terms;-The resident had an activities of daily living (ADL - dressing, eating, bathing, etc.) deficit and required moderate assistance with ADL's related to lower extremity weakness while he/she recovered from diverticulitis. Assist the resident with toileting and incontinence care as needed. The resident required one to two staff assistance. Encourage independence as much as possible.Review of the resident's nurse's progress note dated 03/29/26, at 5:38 P.M., showed Registered Nurse (RN) H documented the following:-The resident received skilled nursing services related to diverticulitis. The resident was cooperative upon approach. The resident had no report of unrelieved pain or discomfort. The resident was alert and oriented to person, place and time. His/her lungs were clear to auscultation (no abnormal breath sounds), respirations were even and unlabored. Staff did not observe a cough and no one reported a cough;-The resident did experience some shortness of breath around 4:00 P.M. The resident said he/she could not breathe and reported being strangled by someone who was in his/her room. Nobody was in the room with the resident at the time. The resident's SpO2 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265157	A. Building B. Wing	04/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Springfield Rehabilitation & Health Care Center	2800 South Fort Avenue Springfield, MO 65807

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(oxygen (O2) saturation in the blood) read 75% (normal is above 90%) per the certified nursing assistant (CNA). Staff obtained oxygen and the resident's SpO2 increased to 95% at the time but the resident still demonstrated shortness of breath. Staff applied O2 at one liter using a nasal canula which helped.(Staff did not document beginning an investigation into the resident's allegation of abuse.)Review of DHSS records showed the facility did not provide an investigation of the resident's allegation of abuse. During an interview on 04/08/26, at 9:37 A.M., RN H said the following: -Allegation the resident made to him/her on 03/29/26 was considered an allegation of abuse and should have been investigated;-Types of abuse included physical, emotional, verbal and neglect;-Social services investigated allegations of abuse;-All allegations of abuse were investigated in house;-If a resident reported someone strangled them, he/she considered that an allegation of abuse and it should be investigated.During an interview on 04/08/26, at 9:21 A.M., Licensed Practical Nurse (LPN) G said the following: -Allegation the resident made about someone strangled him/her in his/her room should have been investigated;-Types of abuse included verbal, mental, physical, elder and financial;-Abuse investigations started with the charge nurse;-The Assistant Director of Nurses (ADON), DON and social services assisted with the investigation;-All allegations of abuse were investigated;-If a resident reported someone strangled them in their room, he/she considered that physical abuse and it should be investigated.During an interview on 04/08/26, at 9:07 A.M., Certified Nursing Assistant (CNA) E said the following:-Types of abuse included emotional, physical, verbal, neglect and financial;-All allegations of abuse were investigated;-The charge nurse and DON investigated allegations of abuse;-If a resident reported that someone strangled them in their room, he/she considered this abuse, and the DON or Administrator should investigate the allegation.During an interview on 04/08/26, at 9:14 A.M., CNA F said the following:-Types of abuse included misappropriation, neglect, sexual, verbal, mental and physical;-The DON and Administrator investigated all allegations of abuse;-If a resident reported to him/her that someone strangled them in their room, he/she considered this an allegation of physical abuse that should be investigated. During an interview on 04/09/26, at 4:56 A.M., RN I said the following:-Types of abuse included physical, neglect, mental, psychological, verbal, sexual and financial;-The ADON, DON and Administrator investigated all allegations of abuse;-If a resident reported someone strangled them in their room, he/she considered that an allegation of physical abuse that should be investigated.During an interview on 04/10/26, at 9:57 A.M., Certified Medication Technician (CMT) J said the following:-Types of abuse included verbal, physical, sexual, neglect and financial;-The DON and Administrator investigated all allegations of abuse even allegations made by residents who had dementia;-If a resident reported someone strangled them in their room, he/she considered that an allegation of physical abuse that should be investigated.During an interview on 04/10/26, at 2:13 P.M., the DON said the following:-The allegation made by the resident (of being strangled) should have been investigated;-He/she had not completed an investigation related to the allegation;-All allegations of abuse were investigated by the DON, ADON and social services.During interviews on 04/08/26, at 9:55 A.M., and on 04/10/26, at 2:13 P.M., the Administrator said the following:-The allegation made by the resident (of being strangled) should have been investigated;-The leadership team was responsible for ensuring staff knew when to report allegations of abuse so they could be investigated;-He was responsible for ensuring allegations of abuse were investigated.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265157	A. Building B. Wing	04/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Springfield Rehabilitation & Health Care Center	2800 South Fort Avenue Springfield, MO 65807

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on observation, interview, and record review, the facility failed to ensure all residents received pain management consistent with standards of practice when staff failed to consistently administer pain medications in a timely manner to one resident (Resident #112). The facility census was 117.Review of a facility policy entitled Preparation and General Guidelines: Medication Administration-General Guidelines, revised 02/25/25, showed the following:-The facility has staff and a medication distribution system to ensure safe administration of medications without unnecessary interruptions;-Medications are administered in accordance with written orders of the prescriber;-Medications are administered without unnecessary interruptions;-A schedule of routine dose administration times is established by the facility and utilized on the administration records;-Medications are administered within 60 minutes before or after the medication administration record (MAR) scheduled times where possible;-Documented administration should be after the administration.1. Review of Resident #112's face sheet (brief look at resident information) showed the following information:-admission date of 02/16/26;-Diagnoses included fractures of lower end of radius (one of the two long bones in the forearm), dislocation of right hip, long-term opioid (a class of drugs used as pain relievers) use, anxiety (mental health condition characterized by excessive worry and fear), depression, chronic pain syndrome (a condition where pain lasts longer than 3-6 months), post-traumatic stress disorder (PTSD-mental health condition triggered by experiencing or witnessing terrifying, life-threatening events), osteoarthritis (a joint disease where cartilage breaks down over time causing pain, stiffness, and joint damage), fibromyalgia (a chronic disorder characterized by widespread musculoskeletal pain, fatigue, sleep disturbances, and cognitive difficulties), and muscle spasms (a sudden, involuntary, and often painful contraction of one or more muscles). Review of the resident's physician order sheet (POS) showed an order, dated 02/16/26, for oxycodone-acetaminophen (APAP) 5-325 milligram (mg) (Percocet - medication used to treat moderate to severe acute pain), give two tablets every four hours as needed by mouth.Review of the resident's care plan, revised on 02/18/26, showed the following information:-Prescribed oxycodone/APAP as needed to help manage acute pain related to right hip dislocation and right wrist fracture;-Pain will be managed at patient's tolerable level;-Administer medications as ordered;-Required moderate assistance with activities of daily living (ADL) related to pain and limited mobility while recovering from a right hip dislocation/fracture and right wrist fracture. Review of the resident's POS, showed an order, dated 02/23/26, for methocarbamol (used to relieve the discomfort caused by acute (short-term), painful muscle or bone conditions) 750 mg tablet for muscle spasms, give one tablet every twelve hours, at 7:00 A.M. and 7:00 P.M.Review of the resident's March 2026 MAR showed methocarbamol 750 mg tablet scheduled to be administered every twelve hours with the morning dose scheduled for 7:00 A.M. Staff administered the medication as follows:-On 03/02/26, staff documented administration at 9:16 A.M.;-On 03/04/26, staff documented administration at 9:21 A.M.Review of the resident's March 2026 MAR showed staff administered oxycodone-acetaminophen 5-325 mg, two tablets, on 03/06/26, at 8:44 A.M. and 2:59 P.M. Both times the resident reported a pain level of seven on a scale of zero to ten.Review of a progress note dated 03/06/26, at 3:26 P.M., showed the following:-The resident verbalized a complaint of pain and was upset that his/her midday pain medication was not given;-The registered nurse (RN) reviewed pain medication orders with the resident;-The resident said the medication technician was late with his/her pain pill;-The RN reinforced education that Percocet was ordered as needed and the resident had to request it, otherwise it would not be given;-The resident requested that the medication technician be instructed to give his/her medication when first requested;-Information was shared with the medication technician.Review of the resident's March 2026 MAR showed methocarbamol 750 mg tablet scheduled to be administered every twelve hours with the morning dose scheduled for 7:00 A.M. Staff administered the medication as follows:-On 03/13/26, staff documented administration at 10:25 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265157	A. Building B. Wing	04/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Springfield Rehabilitation & Health Care Center	2800 South Fort Avenue Springfield, MO 65807

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A.M.;-On 03/16/26, staff documented administration at 11:16 A.M.;-On 03/17/26, staff documented administration at 10:07 A.M.;-On 03/18/26, staff documented administration at 10:24 A.M.;-On 03/19/26, staff documented administration at 11:11 A.M.;-On 03/20/26, staff documented administration at 10:21 A.M;-On 03/25/26, staff documented administration at 10:15 A.M.;-On 03/26/26, staff documented administration at 9:49 A.M.;-On 03/27/26, staff documented administration at 10:23 A.M.;-On 03/28/26, staff documented administration at 10:19 A.M.;-On 03/29/26, staff documented administration at 10:16 A.M.;-On 03/30/26, staff documented administration at 9:26 A.M.;-On 03/31/26, staff documented administration at 11:11 A.M.Review of the resident's April 2026 MAR showed methocarbamol 750 mg tablet scheduled to be administered every twelve hours with the morning dose scheduled for 7:00 A.M. Staff administered the medication as follows:-On 04/01/26, staff documented administration at 10:11 A.M.;-On 04/02/26, staff documented administration at 10:32 A.M. Review of the resident's POS, showed an order, dated 04/02/26, for oxycodone-acetaminophen 5-325 mg tablet for post laminectomy syndrome (a surgical procedure the removes the back part of a vertebra to widen the spinal canal, give two tablets by mouth every twelve hours 9:00 A.M. and 9:00 P.M.Review of the resident's April 2026 MAR showed the following: -Methocarbamol 750 mg tablet scheduled to be administered every twelve hours with the morning dose scheduled for 7:00 A.M;-Oxycodone-acetaminophen 5-325 tablet, give two tablets, was scheduled to be administered every twelve hours with the morning dose scheduled for 9:00 A.M.;-On 04/03/26, staff documented administration of both medications at 10:47 A.M.;-On 04/04/26, staff documented administration of both medications at 10:13 A.M.;-On 04/05/26, staff documented administration of both medication at 10:51 A.M.During an observation and interview on 04/07/26, at 9:58 A.M., the resident said he/she called for his/her pain medication about an hour ago, but the nurse had not brought it him/her. He/She had pain in his/her neck and right arm. The resident was observed in bed with a neck pillow placed around his/her neck.Review of the resident's April 2026 MAR showed the following:-Methocarbamol 750 mg tablet scheduled to be administered every twelve hours with the morning dose scheduled for 7:00 A.M.;-Oxycodone-acetaminophen 5-325 tablet, give two tablets, scheduled to be administered every twelve hours with the morning dose scheduled for 9:00 A.M.;-On 04/07/26, staff documented administration of both medications at 10:14 A.M. on 04/07/26.During an interview and observation on 04/08/26, at 9:58 A.M., the resident said he/she should have received his/her pain medication at 9:00 A.M., but he/she had not received it yet. He/She had pain in his/her neck and right shoulder. He/She rested in bed with a neck pillow around his/her neck. Review of the resident's April 2026 MAR showed the following: -Oxycodone-acetaminophen 5-325 tablet, give two tablets, scheduled to be administered every twelve hours with the morning dose scheduled for 9:00 A.M.;-On 04/08/26, staff documented administration at 10:03 A.M. on 04/08/26.During an interview on 04/06/26, at 10:59 A.M., the resident said the following:-He/She had pain related to numerous injuries from a recent fall at home and he/she had issues getting his/her pain medications;-Getting pain medications had been a constant problem since he/she admitted to the facility;-He/She was not receiving his/her pain medications on time;-His/Her pain medications were scheduled for certain times, and he/she gets them one to two hours later than the scheduled time.During an interview on 04/10/26, at 11:43 A.M., Certified Medication Technician (CMT) J said the following:-The resident has let him/her know several times that his/her pain medications were late;-The resident has complained about late medications every day;-He/She would try to administer the resident's pain medications before he/she complained, but the resident's room was located at the end of the hall and the residents at the end of the hall receive their medications last;-The resident did frequently request pain medication from him/her;-Scheduled medication should be administered within one hour before or one hour after the scheduled time;-It would be considered a medication error if staff administered a scheduled medication outside the one hour before or one hour after timeframe the medication was scheduled for;-If a medication is administered late, he/she documented the late administration in the resident's electronic medical record;-The residents at the end of the hall that he/she worked on (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265157	A. Building B. Wing	04/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Springfield Rehabilitation & Health Care Center	2800 South Fort Avenue Springfield, MO 65807

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	received their medications last;-Residents that resided on the B and C hall typically received their medications late.During an interview on 04/10/26, at 12:06 P.M., CMT C said the following:-The medications that are scheduled for 8:00 A.M. and 9:00 A.M. on the B hall where the resident resided were typically administered late;-The resident gets upset with him/her because it seems like forever before he/she gets to him/her with his/her medications;-He/She thought there was a communication issue with staff, and the resident did not get his/her pain medications as soon as he/she would like;-Staff did not tell him/her that the resident requested pain medication, so he/she did not know to administer the pain medication when the resident requested it;-The resident complained about pain constantly;-After the resident's pain medication changed from as needed to a scheduled time, he/she tried to get his/her pain medication to him/her on time, but he/she still administered it late because the residents on the hall the resident resides on typically receives their medications late;-Scheduled medication should be administered within one hour before or one hour after the scheduled time;-It would be considered a medication error if staff administered a scheduled medication outside the one hour before or one hour after timeframe of the scheduled medication time;-He/She notified the nursing staff when he/she is late passing medications;-He/She documented late medication administrations in the resident's electronic medical record;-Several residents complained about their medications being administered late.During an interview on 04/10/26, at 12:45 P.M., Registered Nurse (RN) P said the following:-The B Hall where the resident resided had the most residents and the residents at the end of the hall receive their medications last, so the medications may be late;-The resident had complained to him/her about late medications in the past, but has not complained about it as much lately;-The resident had several recent injuries, but he/she was not sure what the specific injuries are.During an interview on 04/10/26, at 12:45 P.M., Registered Nurse (RN) P said the following:-Scheduled medication should be administered within one hour before or one hour after the scheduled time;-Scheduled pain medications should be administered on time;-If pain medications were administered outside of the one hour before or one hour after scheduled time, it would be considered a medication error.During an interview on 04/10/26, at 2:30 P.M., the Director of Nursing (DON) said the following:-The resident complained of pain a lot;-He/She initially had pain medication scheduled as needed, but the facility recently had the pain medications scheduled due to the number of complaints the resident made regarding pain;-Scheduled medications should be administered within one hour of the time it is scheduled to be administered;-Medications scheduled as needed should be administered as soon as possible.During an interview on 04/10/26, at 2:30 P.M., the Administrator said the following:-Scheduled medications should be administered within one hour of the time it is scheduled to be administered;-Medications scheduled as needed should be administered as soon as possible.