STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265289	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cox Medical Centers Meyer Orthopedic and Surgical	3535 S National Ave 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 and interview, the facility failed to provide dignity and respect to a resident during a wound care treatment when a staff member argued with one resident (Resident #4) who attempted to direct his/her own care. The facility census was 7.Review of the facility's policy titled Patient [NAME] of Rights, undated, showed the following:-The purpose of the Patient [NAME] of Rights is to inform patients and their family members of their rights and responsibilities;-The facility has defined patient rights and responsibilities to comply with the patient Self-Determination Act, (Health Insurance Portability and Accountability Act (Hippa) and Centers for Medicare and Medicaid Services (CMS) and other applicable regulations and organizational values;-Patients have the right to be treated with respect and dignity. Patients will be cared for in a safe environment that provides personal privacy, preserves dignity and contributes to a positive self-image;-Be involved in their care decisions including but not limited to participating in all decisions related to their health care;-Participate in the development and implementation of their plan of care including but not limited to being involved in care planning, treatment and discharge planning;-Patients have the responsibility to communicate with caregivers their desires and to ask questions to ensure they understand the plan of care being considered. 1. Review of Resident #4's face sheet (admission data) showed an admission date of 03/31/26. Review of the resident's admission Minimum Data Set (MDS-a federally mandated comprehensive assessment instrument completed by facility staff), dated 04/06/26, showed the following:-Cognitive skills intact;-The resident was independent with toileting and mobility. Review of the resident's care plan, revised 04/26/26, showed the patient/family able to effectively weigh alternatives and participate in decision making related to his/her treatment and care. An observation on 04/22/26, at 3:35 P.M., showed the following:-Skin Wound Ostomy Team (SWOT) Registered Nurse (RN) C and Licensed Practical Nurse (LPN) A entered the resident's room to perform wound care on his/her left leg;-The resident lay in bed with a Kerlix (a highly absorbent, 100% cotton fluff gauze with a crinkle-weave pattern, commonly used as a primary or secondary dressing to manage wound drainage) around his/her left leg with serous (a clear, thin, watery plasma that commonly appears during the early stages of wound healing) drainage approximately the size of an egg visible on the left side/back of the Kerlix dressing;-The resident told the RN and LPN the supplies they needed and where they should place the supplies;-The resident asked the nurses to place three disposable pads under his/her legs to catch the saline when they irrigated the wound;-The RN said they did not need to place that many disposable pads under his/her legs as he/she would not need that much saline;-The resident said you will need two bottles of saline and the 60 milliliter (ml) syringe and large plastic graduated container located on a counter in his/her room, to irrigate the wound;-The LPN looked at the container, syringe, and two opened bottles of normal saline and threw them in the trash as no opened date was visible on the items. One unopened bottle of saline remained on the counter along with a pink plastic basin that contained various supplies;-The resident told the nurses they needed the container they threw away to pour saline in when they irrigated the wound with the syringe;-The RN said he/she would not need that large container as he/she would not use that much saline;-The RN asked the resident if he/she could pour saline over the wound, and the (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

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