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 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on interview and record review, the facility failed to develop and update the comprehensive facility assessment annually, in accordance with all applicable Federal requirements. Failure to develop and update the comprehensive facility assessment annually could delay the services needed to care for the residents in day-to-day operations and in emergencies. This failure could affect all facility occupants. The facility census was 7. Review showed the facility did not provide a policy regarding the facility assessment. 1. Review showed the facility did not provide a facility assessment document. During an interview on 04/22/26, at 4:36 P.M., the Administrator said she thought the facility assessment was completed in May 2025 prior to her taking over as administrator. The assessment has not been located. The assessment should be completed annually. The Manager, Assistant Manager, and she were responsible for compliance.During an interview on 04/22/26 at 4:34 P.M., the manager said she was not familiar with the facility assessment and was not part of working on that. During an interview on 04/23/26, at 9:00 A.M., regulatory affairs staff said staff were working on the facility assessment now. She did not have a facility assessment and did not find one. She did not have a policy for the facility assessment. During an interview on 04/23/26. at 9:00 A.M., the Administrator said she did not have a facility assessment.

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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(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 - Minimal harm or potential for actual harm Residents Affected - Some	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 observation, interview, and record review, the facility failed to ensure resident environment remained as free from accident hazards as possible when the facility had water temperatures in excess of 120 degrees Fahrenheit (F) in multiple resident rooms. The facility had a census of 7.Review of the United States Consumer Product Safety Commission (CPSC) document Avoiding Tap Water Scalds, dated 03/2012, showed the following:-Most injuries involving tap water scalds are to the elderly and children under the age of five;-The CPSC urges all users to lower their water heaters to 120 degrees F;-Most adults will suffer third-degree burns if exposed to 150 degrees F water for two seconds;-Burns will also occur with a six-second exposure to 140 degrees F water or with a thirty second exposure to 130 degrees F water;-If the temperature is 120 degrees F, a five-minute exposure could result in third-degree burns Review of the facility water management plan, reviewed [DATE], showed the following:-The Central Domestic Hot Water System identified two gas fired water heaters with 140 degrees F water;-The water distributed to a mixing valve (combines cold and hot water to lower water temperature in transit to final area of use) down to 125 degrees F for building distribution;-The plan also identified three steam powered instant hot water heaters with no mixing valve providing 125 degrees F water to the building. 1. Review showed an outside vendor calibrated the facility multimeter (a device used to measure various electrical currents with some manufactured with ability to measure temperature) on [DATE]. The calibration expired on [DATE]. Observation on [DATE] showed the following resident room hot water temperatures:-At 1:08 P.M., room [ROOM NUMBER] (unoccupied) had a sink water temperature of 133 degrees F. The Engineering Supervisor tested the water temperature with a multimeter. The temperature was 131 degrees F;-At 1:09 P.M., room [ROOM NUMBER] (unoccupied) had a sink water temperature of 134 degrees F. The Engineering Supervisor tested the water temperature with a multimeter. The temperature was 131 degrees F;-At 1:11 P.M., room [ROOM NUMBER] (unoccupied) had a sink water temperature of 137 degrees F. The Engineering Supervisor tested the water temperature with a multimeter. The temperature was 129 degrees F;-At 1:23 P.M., room [ROOM NUMBER] (resident occupied) had a sink water temperature of 132 degrees F and a bathroom sink temperature of 131 degrees F. The Engineering Supervisor tested the main room sink and bathroom sink water temperatures with a multimeter. The main room sink temperature was 127 degrees F. The bathroom sink temperature was 126 degrees F;-At 1:26 P.M., room [ROOM NUMBER] (resident occupied) had a sink water temperature and bathroom sink temperature of 131 degrees F. The Engineering Supervisor tested the main room sink and bathroom sink water temperatures with a multimeter. The main room sink temperature was 126 degrees F. The bathroom sink temperature was 127 degrees F;-At 1:30 P.M., room [ROOM NUMBER] (resident occupied) had a sink water temperature of 131 degrees F and a bathroom sink temperature of 132 degrees F. The Engineering Supervisor tested the main room sink and bathroom sink water temperatures with a multimeter. The main room sink and bathroom sink temperatures were 128 degrees F. Observation on [DATE], at 1:37 P.M., of the boiler/mechanical room showed the following:-The temperature valve set to the second to highest setting (temperature not indicated);-The mixing valve temperature gauge showed 110 degrees F. During an interview on [DATE], at 1:37 P.M., the Regulatory Affairs Safety Coordinator said the facility utilizes instant steam heaters for hot water. The water is initially higher than 120 degrees F to kill bacteria. The water circulates to the mixing valve to lower the water to an appropriate temperature for circulation to the building. The water management policy details the hot water requirements for the facility. The water temperature should be between 105 degrees F and 120 degrees F. The engineering department was responsible for monitoring water temperatures. He/She did not know if the policy showed how often staff should check hot water temperatures. During an interview on [DATE], at 1:38 P.M., the (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Engineering Supervisor said he/she did not know if staff checked the mixing valve temperature gauge for accuracy. Staff visually check the temperature valve and mixing valve gauge for anything unusual. During an interview on [DATE], at 7:31 A.M., Environmental Service Technician (EVS) E said he/she cleaned rooms daily. He/She did not know hot water temperature range requirements. He/She did not know who monitored hot water temperatures or how often. Staff should report concerns about hot water to the Environmental Services Manager and nurses on staff immediately. During an interview on [DATE], at 9:10 A.M., Licensed Practical Nurse (LPN) A said he/she did not know of any reports regarding excessively hot water. He/She did not know temperature range requirements or who monitored water temperatures. Staff should report water temperature concerns immediately to the Assistant Registered Nurse Director and document in the maintenance log system. During an interview on [DATE], at 9:16 A.M., Maintenance Staff F said maintenance monitors water temperatures at the mixing valve in the boiler room. He/She did not know how often monitoring occurred. He/She did not know if the facility had a process for monitoring water temperatures in resident rooms. Staff should input a work order in the maintenance log for any concerns. During an interview on [DATE], at 10:55 A.M., Registered Nurse (RN) B said he/she was unaware of concerns related to hot water. Staff should create a maintenance work order immediately for concerns related to hot water. During an interview on [DATE]., at 1:15 P.M., the Environmental Safety Officer said water temperatures should be according to the water management plan. The policy said water temperatures should be 125 degrees F. Staff monitor water temperatures at the boiler. He/She did not know if staff monitor water temperature at the sinks. The boiler water temperature should not exceed 125 degrees F. The sinks have mixing valves for adjusting the temperature of water received. Staff should contact the engineering department concerning issues with hot water temperatures. The engineering department was responsible for maintaining water temperatures. During an interview on [DATE], at 1:51 P.M., the Administrative Director of Engineering said the facility had recent water temperature fluctuations related to repairs of the hot water mixing valve. On [DATE], at 2:39 P.M., housekeeping staff notified the maintenance department during the weekend of hot water temperatures for 300 hall and 400 hall. Maintenance staff investigated at that time and found environmental services staff hung cleaning equipment on the mixing valve lever preventing proper function. On [DATE], the water recirculating pump did not function properly requiring replacement. Facility staff notified the maintenance department during the weekend of hot water temperatures. Maintenance staff investigated at that time and found environmental services staff hung cleaning equipment on the mixing valve lever preventing proper function. The facility maximum water temperature is 125 degrees F with resident room temperatures requiring temperatures between 105 degrees F and 120 degrees F. The Engineering Supervisor is responsible for compliance. During an interview on [DATE] at 4:34 P.M., the Manager said a hot water issue occurred over the past weekend, but she did not know about it until Tuesday morning ([DATE]). The engineering department was responsible for testing the water. She did not know how often staff check the hot water temperatures. It is important to check the hot water temperatures due to not having it too hot which could cause damage to a resident. During an interview on [DATE], at 4:36 P.M., the Administrator said the engineering department was responsible for monitoring hot water temperatures and checking to ensure proper temperature. Staff should report issues with water temperatures directly to the engineering department. She had not received any reports of concerns related to water being too hot.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to assess risks of entrapment from bed rails prior to installation, failed to ensure that the beds dimensions were appropriate for each resident's size and weight, and failed to develop and implement interventions for the use of side rails on the residents' care plans for three residents (Resident #2, Resident #10, and Resident #11). The facility's census was 7.Review showed the facility did not provide a policy regarding the use of side rails. 1. Review of Resident #2's face sheet (admission data) showed the resident admitted to the facility on [DATE]. Review of the resident's consent to use half side rails showed the following:-The resident's responsible party gave verbal consent for the resident's use of the side rails;-Staff signed the document (after verbal consent) on 01/15/26. Review of the resident's admission Minimum Data Set (MDS-a federally mandated comprehensive assessment instrument completed by facility staff), dated 01/18/26, showed the following:-Moderately impaired cognition;-Independent with rolling left and right;-Required substantial/maximal assistance to transfer to and from a bed to a chair (or wheelchair). Review of the resident's care plan, dated 03/04/26, showed a problem of musculoskeletal with intervention to return the resident's mobility to the safest level of function. Review of the resident's medical record showed staff did not complete or document a side rails assessment or gap measurements for use of the resident's side rails. An observation on 04/21/26, at 10:20 A.M., showed the resident lay in bed with bilateral upper side rails raised and the left lower side rail raised. During an interview on 04/21/26, at 10:20 A.M., Registered Nurse (RN) B said the resident could turn himself/herself side to side independently. Observations on 04/21/26, at 12:52 P.M. and 5:05 P.M., showed the resident lay in bed with bilateral upper side rails raised and the left lower side rail raised. An observation on 04/22/26, at 8:40 A.M., showed the resident lay in bed with bilateral upper side rails raised and the left lower side rail raised. Observation and interview on 04/23/26, at 9:38 A.M, Resident #2 said the following:-His/her upper side rails stay in an upright position;-He/She did not know how to lower the side rails;-He/She used the upper side rails to reposition himself/herself for comfort;-He/She had not noticed gaps in the side rails;-He/She did not know if staff checked the side rails for gaps;-The resident lay in bed with bilateral upper and lower side rails raised. During an interview on 04/22/26, at 1:50 P.M., Assistant Registered Nurse (RN) Director/MDS Care Plan Coordinator said the following:-The resident was unable to get out of bed on his/her own;-The resident's care plan did not include side rails. 2. Review of Resident #10's face sheet showed an admission date of 12/12/25. Review of the resident's consent to use half side rails showed staff contacted the resident's responsible party on 12/25/25 at 2:01 P.M. Review of the resident's care plan, dated 03/01/26, showed staff did not address the use of side rails. Observations on 04/22/26, at 6:56 A.M., showed the resident in bed with both side rails up on both sides of his/her bed. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review showed the facility did not provide or document a side rails assessment or gap measurements for use of the resident's side rails. During an interview on 04/22/26, at 1:50 P.M., the Assistant Manager/MDS Care Plan Coordinator said the resident cannot get up out of bed on his/her own and the side rails are not on the care plan. 3. Review of Resident #11's face sheet showed an admission date of 4/13/26. Review of the resident's consent to use half side rails showed the following:-The resident signed on 04/13/26, at 1:00 P.M.;-Staff signed on 04/13/26 at 1:00 P.M. Review of the resident's care plan last, revised 04/14/26, showed staff did not address the use of side rails. Observations and interview on 04/22/26, at 7:41 A.M., showed the resident in his/her bed with both side rails up at head of his/her bed. The resident said he/she used the side rails for mobility. Review showed the facility did not provide or document a side rails assessment or gap measurements for use of the resident's side rails. During an interview on 04/22/26, at 1:50 P.M., the Assistant Manager/MDS Care Plan Coordinator said the resident's care plan did not have side rails listed. During an interview on 04/22/26, at 1:36 P.M., Licensed Practical Nurse (LPN) A said staff did not direct him/her to complete side rail assessments or gap measurements. 4. During an interview on 04/22/26, at 1:43 P.M., Registered Nurse (RN) B said the following:-Staff review consent upon admission with a resident or responsible party to have side rails;-Staff can place three side rails up, but not four side rails which were considered restricted or a restraint;-He/she did not remember completing a side rail assessment or seeing them on care plans. During an interview on 04/23/26, at approximately 9:00 A.M., RN D said the following:-Staff completed an assessment for residents' cognitive abilities, but they did not complete a specific side rail assessment;-In the previous medical record program, staff had a specific assessment for side rails;-When residents admitted to the unit, they signed a consent for siderails that included the risks of using siderails. During an interview on 04/22/26, at 2:14 P.M., the Physical Therapist said the following:-Therapy staff assess a resident for bed mobility and for both side rails to be placed in the up position;-If a resident did not have safe bed mobility, staff did not raise two side rails up but would lower the rails.-Staff did not put all four side rails up if a resident was confused. During interviews on 04/22/26, at 11:40 A.M. and 1:50 P.M., the Assistant RN Director/MDS Care Plan Coordinator said the following:-Staff raised bilateral upper siderails on all residents' beds admitted to the unit unless they determined the siderails were contraindicated such as with confused residents who could climb over the siderails when getting out of bed;-All residents had a choice to use the siderails and signed consent for the siderails;-Staff should review side rail consent and permission to use or decline upon admission with a resident or responsible party;-She did not enter side rails on the care plans or document side rails as part of the care plan;-The side rails on the beds did not remove (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	but staff could leave the rails down;-Other than the side rail consent form, staff did not complete a specific assessment related to side rails;-Staff assess residents upon admission on their bed mobility. During an interview on 04/22/26, at 4:34 P.M., the Manager said the following:-She was not aware of any assessment completed on side rails;-Staff should look at whether the residents use side rails for mobility to help turn in bed and become more mobile on their own;-Staff should look for gaps in the side rails to ensure the residents did not get any body part caught for safety issue. During interviews on 04/23/26, at 1:52 P.M. and 4:42 P.M., the Administrator said the following:-She expected staff to look for gaps with the side rails on the bed;-Staff could not remove the side rails but can put them down;-Staff should assess a resident's cognitive status and if there are side rail safety issues, place the side rails down;-She did not have a side rail policy and did not have gap measurements and/or bed monitoring documentation.

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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 resident said no, he/she did not want all of that saline on his/her bed and again requested more disposable pads;-The LPN found another syringe in the supply bucket and showed the RN. The resident said that syringe was not big enough and you need to irrigate it using the large syringe. The LPN looked and found another 60 ml syringe;-The resident said on Monday, the nurse practitioner changed the frequency of the dressing change to every three days. This (pointing to the visible drainage on the dressing) is the reason he/she could not go three days without a dressing change; -The resident again asked the nurses to get four 4X4 gauze and more saline, neither nurse acknowledged the resident's request;-The RN told the resident if the drainage was leaking through the (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dressing, they needed to change the Xeroform (a non-adherent wound dressing consisting of fine mesh gauze primarily used to maintain a moist wound environment for low-draining, chronic (continuing or occurring again and again for a long time) wounds). The resident said the absorbent dressing would stick to the wound. The RN said they could replace the ABD pad (thick, highly absorbent medical dressings designed for heavily draining wounds) with the more absorbent dressing. The resident said it would not need that if staff changed it every day; -The resident again asked the RN for four 4X4 gauze. The RN said he/she would not need three gauze; the resident said you will need four. -The RN grabbed his/her scissors and started to lift the Kerlix to cut off the dressing. The resident said do not start until you have all of the supplies assembled, four 4X4 gauze, more saline and a large container and syringe;-The resident then told the nurses to place a table at the end of the bed to set the supplies on. The RN slid out the bottom tray of the resident's bedside table. The resident said no, do not use that, it is dirty. The RN said he/she would clean it and wiped off the bottom tray of the bedside table with a sanitizing wipe. The resident said no, do not use that. They use the table near the window (pointing to a small table with various wound supplies). The LPN removed the items from the table near the window, moved it closer to the bed, but not at the foot of the bed as the resident requested, then cleaned it with a wipe. The LPN picked up supplies to place on the table, but the resident said you need to place something over the table before adding the supplies. The RN placed the pad on the table still wet from sanitizing wipe. The resident said no, you need to dry off the table before placing supplies on it as it could seep through and make the supplies wet. The nurses removed the disposable pad, dried the table with a paper towel, then covered the table with a new disposable pad;-The resident asked the nurses again to get a large container with a syringe to irrigate the wound. The nurse said he/she would not need it and this was what he/she was doing. The resident said you are not supposed to rub the wound and again insisted on the large container with syringe; -The RN disagreed with the resident several times about not needing the large container.-The resident said you could have gotten another one (from the supply room) instead of arguing with him/her;-The RN said, this is how we are doing the dressing change, is that okay? The resident said no, it was not okay;-The resident said ma'am, please, could you get the large container?-The RN and LPN left the room and returned a short time later with a sealed package. The RN opened the package and removed a large syringe and small container from the package;-The resident said please, get the proper materials. He/she did not know why he/she (the RN) was arguing with him/her. He/she (the resident) wanted a large container so they (the nurses) would not need to pour more saline in the container. The large container held enough fluid to complete the irrigation;-The RN said this one (pointing to the smaller container) would work fine;-The resident said it was too small and he/she needed to get one like he/she had;-The LPN said this one (pointing to the small container) was sterile and the one the resident kept requesting was not sterile and was packaged in bulk. The smaller container should work fine;-The resident said the large container was clean and when staff would bring it to him/her, it was covered with plastic; -The RN said he/she had been doing this (dressing changes) for 27 years and this container (pointing to the small container) would work fine. Could he/she just remove the resident's dressing. The resident said place another disposable pad under his/her legs;-The RN started unwrapping the kerlix covering the resident's wound, and the resident again told the nurses they needed to place another disposable pad under her legs. The RN told the LPN to place another pad under his/her legs if it made the resident happy. The LPN complied; -The RN told the resident he/she was sorry but this was his/her first time changing the resident's dressing. The resident said he/she knew that and that was why he/she was telling the RN how to do itl-The resident said ma'am could you just get the large container? The resident said I should not have to go through this;-The RN asked the resident if he/she could remove the dressing. The resident agreed then told the RN how to remove the tape and unwrap the three kerlix wrapped around his/her leg;-The RN filled the syringe with normal saline and turned to moisten the ADB dressing which had visible drainage that leaked through to the outside of the dressing. The resident said, do not saturate (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	my dressing. The RN said he/she would like to wet it. The resident said no, it would come off; -The RN carefully removed the ABD pads and showed a large amount of serous, yellow and bloody drainage on the ABD. The resident said they saturate this pointing to the xeroform still covering the wound;-At approximately 4:05 P.M. (30 minutes after the RN and LPN entered the room), the SWOT Manager and another RN entered the resident's room. The resident looked at the four nurses standing in the room and said he/she did not want an entourage. LPN A left the room followed by the second RN;-The SWOT Manager introduced herself to the resident and RN C saturated the xeroform with saline. After saturating the xeroform, the resident said the RN needed to change his/her gloves. The RN said he/she was just going to remove the old dressing. The resident said no, change your gloves, you have been touching the syringe. The SWOT manager told the RN, Just do it.-The RN changed his/her gloves, and the SWOT manager took over the wound care;-The resident told the SWOT nurse to move the table containing the supplies to end of the bed and the trash can to the right of the SWOT manager. Neither nurse moved the table to the end of the resident's bed as requested;-The SWOT nurse removed the xeroform and showed a large red, open wound, which wrapped around the entire circumference of the resident's leg except for a small vertical strip of skin approximately two centimeters (cm) wide and the length of the wound;-The RN told the SWOT Manager that he/she discussed with the resident that a more absorbent dressing would be better, but the resident did not want that;-The SWOT Manager poured more saline in the small container. The resident told the SWOT Manager he/she wanted her to irrigate the wound vertically, starting at the top then moving down the leg. The SWOT Manager said she did not think that was a big deal, the resident said it was and repeated how he/she wanted the SWOT Manager to irrigate the wound. The SWOT nurse complied;-The resident said he/she needed two more disposable pads under his/her legs. The RN told the resident he/she already had one. The resident said he/she needed another as he/she did not want blood and drainage all over his/her sheets;- The resident looked at his/her wound and told the SWOT Manager that it appeared meaty because the NP changed the order. The SWOT nurse confirmed the NP's order and said they would talk to the NP or physician about the change;-The resident again said he/she wanted another disposable pad under his/her legs. The SWOT Manager asked the RN to get it for the resident;-After irrigating the wound per the resident's directions, the SWOT Manager began drying the wound by patting it with a 4X4 gauze, starting at the top working her way around the resident's leg in a circular. The resident told the SWOT Manager that she needed to start at the top and work her way down the leg. The SWOT Manager said she was going around the wound. The resident said no, go from the top down, vertically, to ensure the entire wound was dried. The SWOT Manager said she did but would do it the way he/she (the resident) wanted. The resident said that was not how he/she wanted it but how it was always done;-While the SWOT Manager performed the resident's wound care, the resident told the nurse, see, if you would have moved the table to where he/she asked (at the foot of the bed), you would not have to twist around, your supplies would be within easy reach;-The SWOT Manager then applied the xeroform per the resident's instructions and before she could start apply the ABD pad, the resident said, change your gloves. The SWOT Manager said the protocol was to change gloves after removing the dirty dressing before applying a clean dressing, and she was going from a clean dressing to another clean dressing. The resident said he/she did not care, the SWOT Manager's hands were sticky from the xeroform. The Manager complied with the resident's request.-The SWOT Manager completed the dressing change and RN C applied lotion to the resident's feet and legs.During an interview on 04/22/26, at 5:22 P.M., RN C and the SWOT Manager said the following:-RN C said he/she worked as a wound nurse for 27 years. The NP ordered staff to clean the resident left leg wound with saline, apply Xeroform, cover with ADB and wrap with kerlix, every 72 hours.;-The SWOT manager said she was RN C's manager. Resident #4 was very picky and not receptive to all plans of care (related to wound management). They had to find a plan that was appropriate for the wound and one that he/she (the resident) agreed with;-RN C said someone told him/her that the resident liked things a certain way. The resident became upset with (continued on next page)

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	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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	him/her (RN C) because he/she was not doing things like he/she (the resident) wanted. The RN C said he/she probably did argue with the resident over the size of container;-The SWOT Manager said the RN used the sterile container because it was cleaner and thought the resident would prefer that;-RN C said he/she used a sterile container and syringe but did not use sterile technique, it was clean technique. The RN said after the interaction, he/she guessed the size of the graduate container did not matter. After he/she completed all of the wound care, he/she told the resident thank you. He/she thought the resident appeared calmer when he/she did as the resident saw fit;-The SWOT Manager said when the resident asked her to change her gloves after applying the xeroform, she tried to educate the resident but decided to just do it if it made the resident more comfortable and less anxious.During an interview on 04/23/26, at 9:46 A.M., the resident sat in his/her bed. The resident said the nurse did not want to use the table to organize his/her wound care materials. The resident informed the wound care nurse other staff organize the wound care material first. The resident did not feel the wound care nurse listened to him/her.During an interview on 04/23/26, at 9:30 A.M., RN D said the following:-Staff should not argue with residents;-If staff and a resident did not agree about a plan of care, staff should have a conversation with the resident, but resident could have their own opinion about their care, and they are allowed to refuse; -Staff should try to honor residents' preferences within reason.During an interview on 04/23/26, at 5:10 P.M., LPN A said the following:-RN C made a point when he/she did not comply with the resident; -We, as nurses, used the container we thought was appropriate for the situation;-The type of container did not necessarily matter but we did not want to compromise with her because where would it stop? He/she would think he/she was right, and we would have no say in the care we provided;-RN C used the type of container and syringe he/she thought the resident wanted, it was sterile and the resident was concerned with germs;-After discussing the incident further, the LPN said if a resident could not control their environment, they could control how other provided their care, and we are their advocates.During an interview on 04/23/26, at 1:52 P.M., the Director said she expected staff to honor resident requests and not argue with a resident regarding care. She expected staff to educate a resident if a request contradicted a physician order and staff should find a compromise to work with the resident. During an interview on 04/23/26, at 2:25 P.M., the Assistant RN Director said the following:-The nurse could not override the provider's orders if a resident did not agree with it. The resident had the right refuse the treatment;-The resident wanted staff to use four 4X4s because at one time, staff did not dry the wound well enough and left it too wet;-It was not okay for staff to be disrespectful or show no concern for a resident;-Resident #4 was very particular but the interaction between him/her and RN C did sound like a power struggle;-Sometimes it was easier to follow a resident's instructions as long as the instructions were not unreasonable such as not following a provider's order.During an interview on 04/23/26, at 4:20 P.M., the RN Director and Administrator/Director said the following:-The RN Director said it was not appropriate for staff to argue with a resident. If they had a disagreement, the two parties should communicate and discuss the issue and come to a reasonable agreement;-The Director said when in the facility, residents did not have a lot of choice and giving them a sense of control could mitigate problems and they may be willing to do things for you;-The RN Director said arguing with a resident is not what we expect of staff. Resident #4 knew his/her treatment. Complaint 2797590

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation and interview the facility failed to obtain specific flush orders and dressing change orders and failed to ensure the physician orders specified which tube staff should administer medications through and which tube staff should administer feedings though for one resident (Resident #5) who had a gastrostomy tube (G-tube - a surgically placed device providing direct access to the stomach for feeding, fluids, and medications when a person cannot eat enough by mouth) and a jejunostomy tube (J-tube - a long-term feeding tube surgically placed through the abdomen directly into the small intestine's middle section (jejunum) to deliver nutrients and medication). The facility's census was 7. Review of the facility's policy titled Tube Feeding, undated showed the following:-Special instructions and procedures outlined below will be followed by licensed nurses upon receipt of a provider order when tube feedings are administered to provide adequate nutrition and fluids to patients with a functioning gastrointestinal (GI -t he body system responsible for digestion) tract but unable to ingest adequate nutrients orally;-Provider will order the type of formula, volume and frequency of feeding;-See specific physician order for Enteral/Tube Feeding Orders for flushing instructions;-Document any residual, flushes and tube placement checks in the gastrointestinal detail section in the electronic health record. 1. Review of Resident #5's face sheet (admission data) showed the resident was admitted to the facility on [DATE]. Review of the resident' care plan, dated 03/31/26, showed the following:-Altered nutrient intake;-Nutrient intake appropriate for improving, restoring or maintaining nutritional needs.(Staff did not care plan interventions related to his/her G-tube/J-tube and tube feedings.)Review of the resident's orders, dated 03/31/26, included the following:-An active order for gastric tube care, sterile water, flush feeding tube with 30 milliliters (ml) of water prior to medication administration, hold feeds. Give each medication separately via feeding tube and flush with 10 ml water between each medication. Flush feeding tube with 30 ml of water to clear residual medication before feeds are resumed;-An active order for wheat dextrin oral powder packet 2 packets, 3 times a day, Mix according to package directions. Can be administered orally or via feeding tube (the order did not specify which tube to use for medication administration).Review of the resident's medical record showed no orders for J-tube flushes or dressing changes to the insertion sites.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:-Cognitively intact;-Had a feeding tube. Review of the resident's medical record showed an order, dated 04/13/26, for Jevity (calorically dense, fiber-fortified therapeutic nutrition that provides complete, balanced nutrition for long- or short-term tube feeding) 1.5 cal, 70 ml/hour for 12 hours from 6:00 P.M. to 6:00 A.M., daily. (The order did not specify which tube to administer the feeding through.)Review of the resident's Avatar flowsheet (for G-tube and J-tube flushes and dressing changes), dated 04/01/26 to 04/22/26, showed the following:-Staff documented flushing the resident's J-tube with sterile water 21 times (the resident did not have an order for J-tube flushes);-Staff documented completing the split gauze dressing intervention (changing the dressing) on the G-tube site six times (the resident did not have an order for the dressing change);-Staff documented completing the split gauze dressing intervention (changing the dressing) on the J-tube site two times.Observation and interview on 04/21/26, at 10:22 A.M., showed the following:-The resident sat in his/her wheelchair in his/her room;-The resident had a G-tube and a J-tube. Each tube insertion site was covered with a gauze dressing.-He/she did not have an appetite and received nutrition through one of the feeding tubes at night. An observation on 04/21/26, at 12:57 P.M., showed the following:-Licensed Practical Nurse (LPN) A entered the resident's room to administer medication through the resident's feeding tube and to change the dressings around the tube insertion sites;-The LPN said he/she administered the resident's medications through the G-tube (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and administered his/her feeding through the J-tube;-The LPN flushed the G-tube with 30 milliliters (ml) of sterile water before and after administering the medication, then flushed the resident's J-tube with 50 ml of water;-The LPN said they changed the T-sponges around each tube insertion site, every day;-The LPN changed the T-sponges from each tube site and dated the sponges.An observation on 04/21/26, at 5:17 P.M., showed the following:-LPN A entered the resident's room to start the resident's continuous enteral feeding;-The LPN prepared the Jevity bottle and tubing then inserted the tubing into the feeding pump; -He/she prepared another bag filled with sterile water for flushes;-The LPN said the resident received 30 ml of water every four hours during the continuous feeding;-The LPN connected the Jevity tubing to the resident's J-tube and set the pump for 70 ml/hour.During an interview on 04/23/26, at approximately 9:00 A.M., Registered Nurse (RN) D said the following:-If a resident admitted with a feeding tube, the provider wrote G-tube/J-tube care orders as well as the tube feeding orders. Sometimes the registered dietician would also write the tube feeding orders;-If a resident did not have orders for dressing or flushes, the nurse could reach out to the provider for those orders;-If the resident did not have orders for flushes or dressing changes, if the nurses completed one of those tasks, there would be nowhere for them to document the task;-If a resident had a G-tube and J-tube, the nurses passed on in reporter which tube to use for which task although there should be orders that instructed staff on the care and use of the tubes. for each;-Resident #5 had a G-tube and a J-tube. They used the G-tube to administer medications and the J-tube to administer his/her feeding;-The RN reviewed the resident's EMR and said he/she did not find an order for J-tube flushes.During an interview on 04/23/26, at 9:30 A.M., LPN A said the following:-The provider entered the orders for tube feedings, insertion site dressing changes and flushes;-On 04/22/26, the LPN asked the Nurse Practitioner (NP) for an order to change the T-sponges around the resident's tube insertion sites;-The LPN reviewed the EMR and did not find an order for J-tube flushes;-When a resident admitted , the nurses wrote report on a Situation, Background, Assessment, Recommendation (SBAR) form, then updated the form as the resident's care needs changed. The nurses used that form to give report to each other;-The LPN showed the surveyor the SBAR for Resident #5 which included specific notations regarding which tube to use for which task; G-tube for medications, J-tube for feeding;-The SBAR also noted a 30 ml water flush every four hours for the J-tube and a 50 ml water flush for the G-tube;-The LPN said when administering medications, they flushed the tube with 30 ml of water, then 10ml between each medication, finishing with a 30ml flush. The LPN did not know if this was entered as a task but knew those instructions did not pop up on their handheld screen when administering medications;-The LPN thought she read an order with instructions on which tube to use but when he/she looked in the medical record, he/she did not find it.During an interview on 04/23/26, at 2:25 P.M., the Assistant RN Director said the following:-When a resident admitted with a feeding tube, the dietician conducted a nutritional review of the resident then worked with the provider to set the feeding rate;-When a resident admitted , they admitted with discharge recommendations that the provider could approve;-The nurses could propose orders for the provider to review and accept or reject;-There should be orders for flushes, dressing changes, feeding type and rate;-The RN reviewed Resident #5's discharge summary and found instructions for staff to use the J-tube for feedings. There was no order for this.During an interview on 04/23/26, at 6:20 P.M., the Administrator/Director and RN Director said the following:-The RN Director said the provider entered orders for G-tube/J-tube care. If a resident had more than one tube, the order should be specific for each tube; -There should be orders for dressing changes and flushes;-The Administrator/Director said the previous medical record software had order sets which included multiple care orders related to a specific device or diagnoses such as feeding tubes.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to maintain an effective and complete infection control program when staff failed to implement Enhanced Barrier Precautions (EBP - an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDRO - microorganisms, predominantly bacteria that are resistant to one or more classes of antimicrobial agents. Although the names of certain MDROs describe resistance to only one agent, these pathogens are frequently resistant to most available antimicrobial agents) that employs targeted gown and glove use during high contact resident care activities) for one resident (Resident #5) who had a gastrostomy tube (G-tube - a surgically placed device providing direct access to the stomach for feeding, fluids, and medications when a person cannot eat enough by mouth) and a jejunostomy tube (J-tube - a long-term feeding tube surgically placed through the abdomen directly into the small intestine's middle section (jejunum) to deliver nutrients and medication). A sample of three residents was selected. The facility census was 7.Review of Centers for Disease Control and Prevention' (CDC) Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of MDROs, dated 04/02/24, showed the following:-MDRO transmission is common in skilled nursing facilities, contributing to substantial resident morbidity and mortality and increased healthcare costs;-EBP are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities;-EBP may be indicated (when Contact Precautions do not otherwise apply) for residents with any of the following: wounds or indwelling medical devices, regardless of MDRO colonization status, and infection or colonization with an MDRO;-Examples of high-contact resident care activities requiring gown and glove use for EBP include dressing, bathing/showering, transferring, providing hygiene, changing linens,changing briefs or assisting with toileting, device care or use of central line (a long, flexible tube inserted into a large vein in the chest, neck, or arm, with the tip ending close to the heart), urinary catheter (a thin, flexible, indwelling urinary tube inserted through the urethra into the bladder to drain urine continuously), feeding tube (a medical device used to deliver liquid food, fluids, and medications directly to the stomach or small intestine), tracheostomy (a surgical procedure that creates an opening, called a stoma, through the neck directly into the windpipe (trachea) /ventilator (a medical machine that helps a patient breathe or fully breathes for them)and wound care of any skin opening requiring a dressing.Review of the facility's policy titled Infection Prevention, reviewed 06/30/25, showed the following:-To reduce or prevent exposure to infectious agents among patients, healthcare workers, visitors, students and volunteers;-Healthcare workers caring for patients in EBP are to perform hand hygiene and don an isolation gown and gloves at the entry way of the patient's room, during high contact resident care activities;-EBP is indicated for residents with any of the following: infected or colonized with a multiple drug resistant organism (MDRO) without a wound, indwelling medical device or secretions or excretions that are unable to be covered or contained; has a wound or indwelling medical device, and secretions or excretions that are unable to be covered or contained and are not known to be infected or colonized with any MDRO; and has a wound or indwelling medical device excretions that are unable to be covered or contained and are not known to be infected or colonized with any MDRO;-For residents for whom EBP is indicated, EBP should be used when performing the following: dressing, bathing, showering, transferring, providing hygiene, changing linens or assisting with toileting, device care or use central line, foley catheter, feeding tube, tracheostomy, ventilator, and wound care (any skin opening requiring a dressing).1. Review of Resident #5's face sheet (admission data) showed an admission date of 03/31/26. Review of the resident's current care plan showed staff did not address or develop interventions for EBP. 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;-Had a feeding tube. Review of the resident's current (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	physician orders showed no orders for EBP.An observation and interview on 04/21/26, at 10:22 A.M., showed the following:-The resident sat in his/her wheelchair in his/her room;-The resident had a G-tube and a J-tube. Both insertion sites were covered with gauze dressing under his/her shirt;-No signage visible on the resident's door indicating EBP;-The resident said staff did not wear isolation gowns when providing care for his G-tube and J-tube.An observation on 04/21/26, at 12:57 P.M., showed the following:-No signage on the resident's door indicating EBP;-Licensed Practical Nurse (LPN) A entered the resident's room and administered medication through his/her G-tube, flushed both feeding tubes, and cleaned and dressed the tubes' insertion sites;-The LPN performed hand hygiene and donned gloves prior to performing G-tube and J-tube care. The LPN did not don an isolation gown.An observation on 04/21/26, at 5:17 P.M., showed the following:-No signage on the resident's door indicating EBP;-LPN A entered the resident's room to start the resident's continuous enteral feeding through his/her J-tube;- The LPN performed hand hygiene and donned gloves prior to performing G-tube and J-tube care. The LPN did not don an isolation gown.During an interview on 04/21/26, at 5:40 P.M., LPN A said the following:-The facility initiated EBP for residents who had indwelling ports (a small, surgical device placed under the skin for long-term, repeated IV access), wounds infected with MDROs, and certain wound appliances such as wound vacs (a medical device that uses suction to accelerate healing for chronic or large acute wounds);-They did not initiate EBP for residents with indwelling catheters or feeding tubes (G-tubes, J-tubes)'-If a resident required EBP, staff placed a sign on the resident's door explaining the precautions, and staff would don gloves and an isolation gown before entering the resident's room;-At that time, they had no residents who required EBP.Observations on 04/22/26 showed no signage on the resident's door indicating EBP.During an interview on 04/22/26, at 10:55 A.M., Registered Nurse (RN) B said the following:-Staff should implement EBP precautions all wounds, catheters, tube feeding, and inserted lines;-Resident #5 should have EBP in place but staff did not implement as required;-He/She did not know why staff missed implementation of EBP for Resident #5;-The Assistant Manager reviews resident status daily regarding need for EBP and should inform nursing staff;-The Assistant Manager and nurses were responsible for implementing EBP when required.During an interview on 04/22/26, at 11:40 A.M., the Assistant RN Director said the following:-They initiated EBP for residents with indwelling catheters, peripherally inserted central catheter (PICC) lines (a long, thin, flexible tube inserted through a vein in the upper arm and guided into a large vein above the heart), chronic (a condition, disease, or problem that persists for a long duration), infected, or deep wounds, and G-tubes and J-tubes.-Either the infection preventionist who assessed an infected wound or the resident's admitting nurse initiated EBP;-When a resident required EBP, staff wore gloves and an isolation gown when assisting the resident with personal care and transfers, and when caring for the tubes; -Resident #5 had a G-tube and J-tube and should have been on EBP. During an interview on 04/23/26, at approximately 9:00 A.M., RN D said the following:-Residents with PICC lines, drain tubes, G/J-tubes and indwelling catheters required EBP;-EBP consisted of staff donning gloves and an isolation gown when performing tasks with personal contact such as administering medications through a G/J-tube;-When a resident required EBP, the provider entered the order for EBP into the EMR. If there was not an order for EBP, the nurses could recommend initiation of EBP, however, usually the provider entered the order;-Resident #5 was not on EBP but met the requirements for EBP;-He/she may have forgotten the resident needed EBP. During an interview on 04/23/26 at 1:52 P.M., the Administrator said the following:-Staff should wear appropriate PPE when assisting residents who have PICC lines, catheters and wounds which make them more at risk for infection;-When staff entered an order for EBP into the new electronic medical record system, it prompted them to look for an infection. The facility has entered a (help) ticket for the software company to review this prompt.During an interview on 4/23/26, at 4:42 P.M., the RN director said she was not familiar with EBP procedures.