

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265473	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/01/2025
NAME OF PROVIDER OR SUPPLIER  Glendale Gardens Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  3535 East Cherokee Springfield, MO 65809	

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.  (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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on interview and record review, the facility failed to ensure all allegation of verbal abuse were reported immediately to facility management and to the State Survey Agency (Department of Health and Senior Services; DHSS) within the required time frame when staff failed to report an allegation of verbal abuse involving one resident (Resident #1) until the following afternoon. The facility census was 99. Review of the facility policy entitled Abuse Prohibition, dated November 2016, showed the following: -It is the purpose of the facility to prohibit mistreatment, neglect, abuse, misappropriation of resident's property, and exploitation of any resident; -Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Instances of abuse of all residents, irrespective of any mental or physical condition cause physical harm, pain or mental anguish. It includes verbal abuse and mental abuse. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm; -Mistreatment means inappropriate treatment or exploitation of a resident; -To assure that everything possible is being done to prevent abuse, the facility has implemented component processes including training, initial and ongoing of employees; prevention of abuse, neglect or mistreatment or any of the types of abuse; identification of suspicious events; protection of residents during an investigation; investigation of all alleged violations; and response and reporting of an abusive situation to necessary agencies. 1. Review of Resident #1's face sheet (gives basic profile information) showed the following: -admission date of 01/09/17; -Diagnoses included anxiety, insomnia, generalized muscle weakness, pain, diarrhea, abnormalities of gait and mobility, and limitation of activities due to disability. Review of the resident's annual Minimum Data Set (MDS - a federally mandated comprehensive assessment tool completed by facility staff), dated 05/09/25, showed the following information: -Cognition intact; -Adequate hearing without assistive devices; -Required moderate assist with upper body dressing, personal hygiene, and bed mobility; -Required substantial assist with showers/bathing, sitting/lying; -Dependent on others for assistance with toileting hygiene, lower body dressing and footwear, sit to stand, and transfers. Review of the resident's care plan, updated 05/27/25, showed the following: -Required assistance of 1 to 2 staff for all activities of daily living (ADLs) including transfers and positioning, hygiene, long distance mobility, incontinence care, bathing; -At risk for complications due to use of psychoactive medications to treat/manage depression. During an interview on 06/21/25, at 4:40 P.M., Licensed Practical Nurse (LPN) A said the following: -During the evening on 06/20/25, Certified Medication Technician (CMT) B told LPN A that Certified Nursing Assistant (CNA) C was rude and verbally abusive to the resident; -LPN A said around 11:00 P.M. he/she went to interview the resident, but the resident was asleep. He/she did not notify the Director of Nursing (DON) or Administrator of the allegation at that time, because he/she had not yet interviewed the resident to confirm or clarify the allegation; -LPN A said he/she spoke with the resident that morning, and the resident said CNA C was short with him/her the previous evening; -LPN A said he/she did not inform the DON of the abuse allegation until 06/21/25, when the LPN called the DON to inform her that a State Surveyor was in the building to investigate a reported complaint. Review of DHSS facility records showed no self report received regarding the allegation of abuse. During an interview on 06/21/25, at 4:52 P.M., CMT B said the following: -On 06/20/25, while he/she was doing his/her last medication pass of the shift, CNA C stood in the hallway approximately five feet from the resident's doorway. CNA C was complaining about the resident having diarrhea and having to change him/her again. The CNA loudly said, What the hell does he/she want now?! I don't know how the fuck he/she could have that much diarrhea! -CMT B went into the resident's room to talk to him/her. The resident looked tearful and said CNA C told him/her he/she would just have to wait for assistance; -CMT B said residents could probably hear the CNA's comments; -CMT B said he/she reported the incident to LPN A and believed the nurse would report the allegation to the DON. During an interview on 07/01/25, at 11:15 A.M., CNA D said staff should tell the charge nurse or the DON if they witnessed or were told allegations of abuse, neglect, or rude staff behavior. The facility has two hours to report abuse allegations to the State. During an interview on 07/01/25, at 11:55 A.M., LPN E said any witnessed or reported abuse should be reported to the State within two hours. During an interview on 07/01/25, at 12:02 P.M., Registered Nurse (RN) F said an allegation of abuse should be reported to the State within two hours. During an interview on 07/01/24, at 11:37 A.M., the Activities Director said staff should report any witnessed or verbalized allegation of abuse so the facility management can report the allegation to the State. During an interview on 06/21/25 at 5:04 P.M. the DON said he/she</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>(continued on next page)</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on interview and record review, the facility failed to document a timely and thorough investigation, to include interviews with multiple staff and other residents, and steps taken to protect all residents during the investigation for an allegation of possible verbal abuse involving one resident (Resident #1). The facility census was 99. Review of the facility policy entitled Abuse Prohibition, November 2016, showed the following: -It is the purpose of the facility to prohibit mistreatment, neglect, abuse, misappropriation of resident's property, and exploitation of any resident; -Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Instances of abuse of all residents, irrespective of any mental or physical condition cause physical harm, pain or mental anguish. It includes verbal abuse and mental abuse. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm; -Mistreatment means inappropriate treatment or exploitation of a resident; -To assure that everything possible is being done to prevent abuse, the facility has implemented component processes including -training, initial and ongoing of employees; -prevention of abuse, neglect or mistreatment or any of the types of abuse; identification of suspicious events; protection of residents during an investigation; investigation of all alleged violations; and response and reporting of an abusive situation to necessary agencies. 1. Review of Resident #1's face sheet (gives basic profile information) showed the following: -admission date of 01/09/17; -Diagnoses included anxiety, insomnia, generalized muscle weakness, pain, diarrhea, abnormalities of gait and mobility, and limitation of activities due to disability. Review of the resident's annual Minimum Data Set (MDS - a federally mandated comprehensive assessment tool completed by facility staff), dated 05/09/25, showed the following information: -Cognition intact; -Adequate hearing without assistive devices; -Required moderate assist with upper body dressing, personal hygiene, and bed mobility; -Required substantial assist with showers/bathing, sitting/lying; -Dependent on others for assistance with toileting hygiene, lower body dressing and footwear, sit to stand, and transfers. Review of the resident's care plan, updated 05/27/25, showed the following: -Required assistance of 1 to 2 staff for all activities of daily living (ADLs) including transfers and positioning, hygiene, long distance mobility, incontinence care, and bathing; -At risk for complications due to use of psychoactive medications to treat/manage depression. During an interview on 06/21/25, at 4:40 P.M., Licensed Practical Nurse (LPN) A said the following: -During the evening on 06/20/25, Certified Medication Technician (CMT) B told LPN A that Certified Nursing Assistant (CNA) C was rude and verbally abusive to the resident; -Around 11:00 P.M., LPN A went to interview the resident, but the resident was asleep. He/she did not notify the Director of Nursing (DON) or Administrator of the allegation at that time, because he/she had not yet interviewed the resident to confirm or clarify the allegation; -LPN A said he/she spoke with the resident that morning, and the resident said CNA C was short with him/her the previous evening. LPN A did not inform the DON of the abuse allegation until 06/21/25, when the LPN called the DON to inform her that a State Surveyor was in the building to investigate a reported complaint; -LPN A said he/she did not remove CNA C from the worksite the previous evening. CNA C worked through his/her shift (2:00 P.M. - 10:00 P.M.). Review of facility provided records showed no documentation of a timely and complete investigation or staff taken to protect all residents during the investigation of the allegation of abuse. During an interview on 06/21/25, at 4:52 P.M., CMT B said the following: -On 06/20/25, while he/she was doing his/her last medication pass of the shift, CNA C stood in the hallway approximately five feet from the resident's doorway. CNA C was complaining about the resident having diarrhea and having to change him/her again. The CNA loudly said, What the hell does he want now?! I don't know how the fuck he/she could have that much diarrhea! -CMT B went into the resident's room to talk to him/her. The resident looked tearful and said CNA C told him/her he/she would just have to wait for assistance; -CMT B said CNA C had at other times come out of other resident rooms complaining; -The CMT said residents could probably hear the CNA's comments. CMT B reported the incident to the charge nurse, LPN A. During an interview on 07/01/25, at 11:15 A.M., CNA D said staff should tell the charge nurse or the DON if they witnessed or were told allegations of abuse, neglect, or rude staff behavior. The alleged abuser should be separated from the residents. The facility management would begin an investigation. During an interview on 07/01/25, at 11:55 A.M., LPN E said after any witnessed or reported abuse the alleged perpetrator should be walked out of the building, and the charge nurse or management should begin an investigation immediately. During an interview on 07/01/24 at 11:37 A.M. the Activities Director said staff</p>		