STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265473	A. Building B. Wing	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glendale Gardens Nursing & Rehab	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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265473	A. Building B. Wing	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glendale Gardens Nursing & Rehab	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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to notify all residents' families and physicians of all changes in condition and incidents when staff did not notify the physician and family of falls in a timely manner for two residents (Resident #1and #3). The facility census was 93. Review showed the facility did not provide a policy regarding falls or physician notification. Review of the facility policy titled Charting and Documentation, undated, showed the following:-The purpose of these guidelines is to provide a complete account of the resident's care, treatment, response to care and progress; guidance to the physician in prescribing appropriate medications and treatments; assistance in the plan of care for each resident; and an information source for resident changes;-Accidents/Incidents documentation does not take the place of the Event Report Form. Documentation should include circumstances surrounding the accident or incident; where the accident or incident took place; date and time the incident occurred; name of the witness and their account of the accident or incident; resident's account of accident or incident; time the physician was notified as well as the time the physician responded; the date and time the family was notified; the condition of the resident, to include vital signs; disposition of the resident; and all pertinent observations. 1. Review of the Resident #1's face sheet (a document that gives a resident's information at a quick glance) showed the following:-admission date of 03/27/25; -Diagnoses included non-Hodgkin lymphoma (cancer that is in the lymphocytes (white blood cells - a component of the immune system) and osteoarthritis (joint disease that causes pain, stiffness, and loss of function). Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 10/01/25, showed the resident was cognitively intact and required moderate staff assistance with dressing and shower and supervision with toileting. Review of the resident's care plan, revised on 11/05/25, showed the following:-Resident required one-to-two-person assistance with activities of daily living (ADL-basic tasks done regularly to care for the body) due to weakness;-Required one staff assistance with transfer, positioning, and hygiene;-Resident at risk for falls related to decreased mobility.Review of the resident's nursing progress note, dated 06/01/2025, showed the certified medication technician (CMT) reported the resident was on the floor. Resident reported he/she went to the restroom without a walker and on the way out lost his/her balance. Resident reported hitting right side of breast hard on the arm of a wheelchair nearby. Resident denied hitting head or pain. Resident able to move all extremities with good range of motion. Right side of breast noted to be red. Staff will monitor breast for any changes. Staff notified family of fall. Neurological assessment started. (Staff did not document notification of the resident's physician regarding the fall). Review of the resident's nursing progress note, dated 09/22/25, showed resident continued fall follow up due to a fall on 09/21/25 with no complaint of any discomfort at this time. Review of the resident's progress notes showed staff did not document a fall on 09/21/25 or family and physician notification of the fall. Review of the resident's nursing progress note dated 11/01/25, at 6:49 P.M., and recorded as late entry on 11/02/25 at 4:53 P.M., showed resident looked tired and reported he/she was very tired and weak. He/she slid from the recliner due to legs giving out and no energy. He/she again slid from bed, but denied falling. Resident reported sliding from the bed due to very weak legs. (Staff did not document physician or family notification of the resident's falls.) Review of the resident's nursing progress note dated 11/03/25, at 11:31 P.M., showed at 6:00 P.M. the resident fell on the way out of the bathroom. Resident was utilizing a walker and turned, lost balance, and landed on the floor. Resident found lying on his/her back. Resident complained of back pain which was not new to him/her. X-ray results negative on his/her back today before this fall. Roommate witnessed the fall. Resident able to move all extremities with no pain and denies hitting his/her head. (Staff did not document notification of the resident's physician or family of the fall.) During an observation and interview on 11/05/25 at 10:15 A.M. with resident #1 showed the resident in room sitting in a recliner with walker sitting next to resident. Resident reports he/she had four falls in the last week. During an interview on 11/05/25, at 3:45 P. M., Licensed Practical Nurse (LPN) D said the resident slipped out of the recliner and bed one night. He/she did not notify the physician because he/she did not consider sliding from the bed or a chair a fall. The resident had a fall on the way to the bathroom the day after he/she slid from the chair and bed. He/she notified the family but did not notify the physician. The resident had an x-ray to the back due to complaint of back pain before the fall. 2. Review of the Resident #3's face sheet showed the following:-admission date of 09/10/25; -Diagnoses included high blood pressure and lung cancer. Review of the resident's annual MDS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265473	A. Building B. Wing	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glendale Gardens Nursing & Rehab	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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265473	A. Building B. Wing	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glendale Gardens Nursing & Rehab	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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide care per standard of practice when staff failed to document follow-up regarding edema (swelling/fluid retention), failed to obtain orders for the use of Tubi grips (a reuseable tubular elastic bandage used to provide support and compression,) and failed to care plan related to edema for one resident (Resident #1) and when staff failed to complete ordered daily weights and update the care plan related to edema for one resident (Resident #2). The facility census was 93. Review of the facility policy titled Physician Orders, undated, showed the following:-Current list of orders must be maintained in the clinical record of each resident to avoid confusion and errors;-Physician orders must be reviewed and renewed;-Treatment orders should specify what is done, location and frequency, and duration of the treatment. Review of the facility policy titled Care Plan Comprehensive, undated, showed the following:-An individual comprehensive care plan should include measurable goals and timeframes;-The comprehensive care plan will be based on a thorough assessment that includes, but is not limited to the Minimum Data Sheet (MDS - a federally mandated assessment instrument completed by facility staff);-A well-developed care plan will be oriented to preventing avoidable declines in functioning or functional levels; managing risk factors to the extent possible; applying current standards of practice in the care planning process; evaluating treatment of goals, timetables, and outcomes of care; and assessing and planning for care to meet the resident's medical, nursing, mental, and psychosocial needs;-The interdisciplinary care team is responsible for reviewing and updating the care plan when a significant change has occurred, quarterly, and when changes that impact resident care occur. 1. Review of the Resident #1's face sheet (a document that gives a resident's information at a quick glance) showed the following:-admission date of 03/27/25; -Diagnoses included non-Hodgkin lymphoma (cancer that is in the lymphocytes (white blood cells - a component of the immune system), varicose veins of lower extremities (swollen, and twisted veins), high blood pressure, and cardiovascular disease (group of diseases that affect the heart and blood vessels). Review of the resident's quarterly MDS, dated [DATE], showed the following:-Cognitively intact;-Required moderate staff assistance with dressing and shower and supervision with toileting;-Utilized a walker.Review of the resident's nursing progress note, dated 04/01/25, showed resident had some swelling to feet, ankles, and legs. Staff contacted the physician contacted and nurse practitioner (NP) will look at tomorrow. Review of the resident's progress notes showed staff did not document monitoring or the resident swelling or physician/NP response to swelling. Observation and interview on 11/05/25, at 10:15 A.M., showed the resident sitting in a recliner with Tubi grips in place to both lower extremities. He/she reported swelling to the legs on and off. Observation and interview on 11/05/25, at 4:05 P.M., showed the resident observed sitting in a recliner wearing Tubi grips on both legs. Resident reported the certified nurse assistant (CNA) applied the Tubi grips in the morning and removed them at night. Resident reported that he/she also applied them at times. Review of the resident's care plan, revised on 11/05/25, showed the following:-Resident required one-to-two-person assistance with activities of daily living (ADL-basic tasks done regularly to care for the body) due to weakness;-Required one staff assistance with transfer, positioning, and hygiene.(Staff did not care plan related to the use of Tubi grips.) Review of resident's current Physician Order Sheet (POS) showed staff did not document an order for use of Tubi grips.During an interview on 11/05/25, at 3:35 P.M., Certified Nurse Aide (CNA) A said the resident wore Tubi grips. The CNA that gets him/her up in the morning puts them on and they are removed at night. During an interview on 11/05/25, at 3:45 P.M., Licensed Practical Nurse (LPN) D the resident does not wear Tubi grips and does not have an order. During interviews on 11/05/25, at 2:40 P.M. and 3:40 P.M., the MDS Coordinator said he/she was unsure if the resident wore Tubi grips, but the resident does not have an order in the chart. During an interview on 11/05/25, at 4:15 P.M., the Director of Nursing (DON) said the resident does not have an order for Tubi grips to be applied. 2. Review of the Resident #2's face sheet showed the following:-admission date of 05/13/24;-Diagnoses included edema, high blood pressure, and chronic respiratory failure (condition where the lungs are unable to exchange oxygen and carbon dioxide between the body and the environment). Review of the resident's care plan, revised on 06/13/24, showed the following:-Required one staff assistance with ADL's due to weakness;-Monitor weights per physician orders. Notify physician and responsible party of significant weight changes. Review of the resident's quarterly MDS, dated [DATE], showed the following:-Cognitively intact;-Dependent on staff for transfers, mobility, dressing, and showering;-Wheelchair used for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265473	A. Building B. Wing	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glendale Gardens Nursing & Rehab	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 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. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265473	A. Building B. Wing	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glendale Gardens Nursing & Rehab	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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed ensure an environment as free from accident hazards as possible when staff failed to analyze and identify the risks for falls, failed to implement new intervention to prevent future falls, and failed to care plan regarding new falls for three residents (Resident #1, #3, and #4) that sustained falls. The facility census was 93. Review showed the facility did not provide a policy regarding falls. Review of the facility policy titled Care Plan Comprehensive, undated, showed the following:-An individual comprehensive care plan should include measurable goals and timeframes;-The comprehensive care plan will be based on a thorough assessment that includes, but is not limited to the Minimum Data Sheet (MDS - a federally mandated assessment instrument completed by facility staff);-A well-developed care plan will be oriented to preventing avoidable declines in functioning or functional levels; managing risk factors to the extent possible; applying current standards of practice in the care planning process; evaluating treatment of goals, timetables, and outcomes of care; and assessing and planning for care to meet the resident's medical, nursing, mental, and psychosocial needs.-The interdisciplinary care team is responsible for reviewing and updating the care plan when a significant change has occurred, quarterly, and when changes that impact resident care occur. 1. Review of Resident #1's face sheet (a document that gives a resident's information at a quick glance) showed the following:-admission date of 03/27/25; -Diagnoses included non-Hodgkin lymphoma (cancer that is in the lymphocytes (white blood cells - a component of the immune system) and osteoarthritis (joint disease that causes pain, stiffness, and loss of function). Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 10/01/25, showed the resident was cognitively intact and required moderate staff assistance with dressing and shower and supervision with toileting.Review of the resident's care plan, revised on 04/04/25, showed the following:-Resident at risk for falls related to decreased mobility and disease process;-Assess comfort and provide interventions during periods of restlessness;-Assist to the restroom before and after meals, bedtime, and as needed;-Assure resident wears eyeglasses;-Call light and personal items within reach;-Encourage resident to use environmental devices as needed;-Ensure proper footwear;-Bed in low position;-Obtain physical therapy consult as needed. Review of the resident's nursing progress note dated 05/07/25, at 1:00 A.M. showed the resident had an unwitnessed fall in the restroom while a certified nurse aide (CAN) was in the room. The CNA turned to obtain supplies for the resident and resident fell toward the right and hit his/her head on the wall next to the shower. Resident remained conscious and was able to follow commands. No red drainage noted. No bruise noted on head. Turned resident over to back and range of motion performed on right arm without difficulty. Faint lavender bruise noted on right side. Assisted up to toilet with one person assist. Resident complained of headache, rated at a 10 out of 10 on pain scale and pain medication administered. Vital signs and neurological monitoring started. Review of the resident care plan, revised 11/05/25, showed staff did not update the care plan with the fall on 05/07/25 or any new interventions to prevent future falls. Review of the resident's record showed staff did not document an investigation into the fall, the cause of the fall, and any new interventions to prevent future falls. Review of the resident's nursing progress note, dated 06/01/25, showed the certified medication technician (CMT) reported the resident was on the floor. Resident reported he/she went to the restroom without a walker and on the way out lost his/her balance. Resident reported hitting right side of breast hard on the arm of a wheelchair nearby. Resident denied hitting head or pain. Resident able to move all extremities with good range of motion. Right side of breast noted to be red. Will monitor breast for any changes. Family notified of fall. Neurological assessment started. Review of the resident care plan, revised 11/05/25, showed staff did not update the care plan with the fall on 06/01/25 or any new interventions to prevent future falls. Review of the resident's record showed staff did not document an investigation into the fall, the cause of the fall, and any new interventions to prevent future falls. Review of the resident's nursing progress note, dated 09/22/25, showed resident continued fall follow up due to a fall on 09/21/25 with no complaint of any discomfort at this time.Review of the resident care plan, revised 11/05/25, showed staff did not update the care plan with the fall on 09/21/25 or any new interventions to prevent future falls. Review of the resident's record showed staff did not document an investigation into the fall, the cause of the fall, and any new interventions to prevent future falls. Review of the resident's nursing progress note dated 11/01/25, at 6:49 P.M., showed resident looked tired and reported he/she was very tired and weak. He/she slid from