

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 03/04/2026
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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>Based on interview and record review, the facility failed ensure all allegations of possible abuse were reported to the State Survey Agency (SSA - Department of Health and Senior Services (DHSS)) within two hours of staff becoming aware of the allegation when the facility failed to report an allegation of staff to resident abuse involving one resident (Resident #1) until two days after the facility staff became aware of the allegation. The facility census was 99. Review of the facility policy titled Response and Reporting Guidelines, dated March 2016, showed the following:-It is the purpose of the facility to report all substantiated incidents of abuse or neglect to the appropriate state agencies and the designated individuals at the facility's consultant office;-Report any and all cases of alleged resident neglect, abuse and misappropriation of resident property by facility employees, contract employees, volunteers, contract services, consultants, physicians, visitors, family members, or other individuals;-Report immediately, but not later than two hours after forming the suspicion;-This report will be to the hot-line number and or DHSS.1. Review of Resident #1's face sheet (a brief resident profile sheet) showed the following information:-admission date of 02/05/26;-Diagnoses included Parkinson's Disease (a movement disorder of the nervous system), chronic obstructive pulmonary disease (progressive lung disease that blocks air flow making breathing difficult), atrial fibrillation (a rapid irregular heartbeat), and dementia.Review of the resident's admission Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 02/17/26, showed the following information:-Moderate cognitive impairment;-Utilized a wheelchair for mobility;-Frequently incontinent of bowel and bladder.Review of the resident's care plan, revised 02/17/26, showed the following information:-Resident had cognitive impairments related to the use of psychotropic medications;-Resident was at risk for falls due to weakness, medications and gait disturbance.Review of the facility's investigation summary documentation, dated 03/02/26 , showed the following information:-The resident alleged that a male was calling the resident names and threw him/her in the bed;-On 02/28/26, facility staff became aware of the incident;-On 02/28/26, facility staff notified the Director of Nursing (DON) of the allegation;-On 03/01/26, the DON notified the Administrator of the incident;-On 03/02/26, the Administrator interviewed the resident regarding the allegation;-On 03/02/26, at 10:00 A.M., the Administrator notified DHSS, the Ombudsman and the Police Department of the incident.-On 03/02/26, the Administrator notified the resident's daughter of the incident;-On 03/02/26, the Administrator instructed the DON to notify the Physician of the incident.Review of DHSS records showed the facility self-report the allegation of abuse on 03/02/26, at 10:19 A.M.Review of a handwritten statement date 02/28/26, at 5:00 P.M., showed Licensed Practical Nurse (LPN) B's noted the following: -On 02/28/26, between 3:00 P.M. and 4:00 P.M., the resident's family member expressed concerns to LPN B, witnessed by LPN A;-The family member reported that the resident said that he/she was tossed roughly into bed by a male CNA who worked the night shift;-The family member also said that the same male CNA also cursed at the resident;-The family member immediately demanded that the male CNA not provide care to the resident.During an interview on 03/04/26, at 2:17 P.M., LPN B confirmed his/her written statement and said the following: -LPN B confirmed that the resident's family member reported to him/her that a male CNA (continued on next page)</p>

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>who worked the night shift had thrown the resident in the bed and cursed at the resident;-He/she immediately called and reported the allegation to the DON;-The allegation was considered physical and verbal abuse and should be reported to the DON immediately;-The facility had two hours to report abuse to the State.During an interview on 03/04/26, at 2:25 P.M., LPN A said the following: -On 02/28/26, between 3:00 P.M. and 4:00 P.M., he/she overheard the resident's family member at the desk telling LPN B that the resident reported to him/her that a male aide had been rough with cares;-The family member reported to LPN B that he/she did not know the CNA's name, only that he/she was male and worked the night shift;-LPN B immediately called the DON and reported the allegation;-The facility has two hours to report abuse to State.During an interview on 03/04/26, at 9:10 A.M., LPN D said the following: -Any allegation of abuse should be reported immediately to the charge nurse or the DON;-The facility had two hours to report abuse allegations to the State. During an interview on 03/04/26, at 10:15 A.M., CNA E said the following: -The facility had two hours to report to State;-He/she considered cursing and rough cares abuse and would report that immediately. During an interview on 03/04/25, at 10:20 A.M., CNA F said the following:-He/she would notify his/her charge nurse of the DON immediately of any allegation of abuse;-The facility had two hours to report abuse to State;-Rough cares and cursing should be reported immediately. During an interview on 03/04/26, at 2:45 P.M., the ADON said the following: -She was not notified of any abuse allegation regarding the resident;-Staff should notify the DON immediately of any abuse allegation;-The facility had two hours to report abuse to the state;-Rough cares and cursing would be considered abuse and should be reported immediately.During an interview on 03/04/26, at 4:00 P.M, the DON said the following information:-On 02/28/26, the resident's family member came to the facility complaining that the resident got thrown into bed;-The DON said he/she felt like the family was complaining to complain;-He/she should have called the Administrator immediately;-The DON called the Administrator the next night, on 03/01/26 and reported what the family member said;-On 03/02/26, the Administrator came to the facility to start the investigation and said it should have been reported to DHSS immediately. During an interview on 03/04/26, at 4:30 P.M., the Administrator said the following information:-On 03/01/26, at 10:28 P.M., the DON called the Administrator and informed him of an allegation of abuse;-On 03/02/26, at 10:00 A.M., the Administrator reported the allegation to DHSS and started an investigation;-An allegation of rough cares and cursing was physical and verbal abuse;-The facility had two hours to report abuse allegations to DHSS;-The allegation should had been reported immediately, and the facility failed to report the allegation within the two-hour time frame.Complaint #2791690</p>		