STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265477	A. Building B. Wing	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Springfield Skilled Care Center	2401 West Grand Springfield, MO 65802

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48534 Based on observation, interview, and record review, the facility failed to ensure a clean and homelike environment for all residents when staff failed to adequately and in a timely manner clean the floor of the resident room and failed to change the soiled bedding for one resident (Resident #2). The facility census was 110. Record review of the facility's policy titled, Resident Room Cleaning Procedures, dated 05/09/23, showed the following: -In each room bag and remove all trash from room. Clean inside and outside of trash cans when needed; -Always disinfect high touch areas in resident rooms; -Sweep bathroom and resident room floor, including under the bed. If the bed can be moved, move and clean the floor up against the wall; -Mop the resident room floor first and mop the bathroom floor last; -Identify and report any maintenance or cleanliness issues. Record review of the facility's policy titled, Cleaning Detail Forms, undated, showed the following: -Clean and disinfect the resident room using disinfectant cleaner and cleaning clothes; -Clean the patient bed, raise and wipe down arm rails - high touch areas, wipe foot of bed, and if the call box or phone is on the bed wipe these down at this time; -Final check for room cleanliness, mop floor; -Remove all soiled line. Remove linen from bed one piece at a time and place into linen hamper; -Clean and disinfect the patient bed using disinfectant cleaner and cleaning cloths; (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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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Clean mattress - top and bottom. 1. Review of Resident #2's face sheet (resident's information at a quick glance) showed admitted [DATE]. Review of the resident's annual Minimum Data Set (MDS-a federally mandated assessment tool completed by staff), dated 07/30/24, showed the following: -Moderate cognitive impairment; -Uses a wheelchair; -Frequently incontinent of bladder and bowel. Review of the resident's care plan, updated 08/19/24, showed the staff to provide resident with a homelike environment. The resident preferred consistent care routines. Observation of the resident's room, located on the special care unit, showed the following: -On 08/30/24, at 8:50 A.M., the floor next to the the resident's bed was be covered in a dried, yellow in color liquid with papers dried and stuck to floor. There were three dry, dark brown objects, formed like a sausage but with cracks on the surface, and what appeared to be human feces under the resident's bed. There was a strong odor of urine in the room. The resident was laying in bed covered by two blankets. -On 08/30/24, at 10:26 A.M., the resident's bed had been made. The top two covers on the resident's bed were pulled back showing dirt and debris in the resident's bed along with two large wet spots, yellow in color, on the bedding that smelt like urine. -On 08/30/24, at 10:55 A.M., the resident's floor was in the same condition with the three objects on the floor along with the dried liquid next to the resident's bed. The resident's bed was also in the same condition. -On 08/30/24, at 11:31 A.M., the resident's bed and floor were in the same condition. -On 08/30/24, at 1:10 P.M., the resident's bed and floor were in the same condition. During an interview on 08/29/24, at 9:31 A.M., Certified Nursing Assistance (CNA) E said housekeeping does not come back to the special care unit (unit). Nursing staff clean the resident's rooms. During interviews on 08/30/24, at 1:12 P.M., and 6:12 P.M., CNA F said the following: -Housekeeping was in the unit this morning and was called to another floor so nothing got done; -CNA F had to stop cleaning to get supplies; -The aides were responsible for cleaning the dining room tables and taking out the trash; (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Resident bedding was changed as needed; -The resident won't let staff touch his/her stuff or change his/her bed; -The resident gets angry and violent; -If urine was on the floor he/she would clean it up; -The housekeeping department was responsible for cleaning the residents' rooms; -Aides are responsible for cleaning up bodily fluids to include urine and feces; -The resident was very possessive and does not like his/her bedding changed; -He/she did not notice the dried liquid or what appeared to be feces on the floor by the resident's bed. During an interview on 08/30/24, at 1:56 P.M., Certified Medication Tech (CMT) G said the following: -The housekeeping department was short staffed and it was everybody's responsibility to clean right now; -The aide that works the unit on third shift did a majority of the cleaning on the unit; -The day shift aides on the unit were not very good at cleaning resident's rooms. Observation and interview on 08/30/24, at 5:36 P.M., with Registered Nurse (RN) B showed the following: -RN B said the CNAs are responsible for changing residents' bedding; -RN B pulled back the resident's top two blankets showing dirt and debris in the bed; -RN B continued to pull back blankets three and four, showing five large yellow in color dried spots on the resident's blankets; -RN B pulled back the chuck pad on the resident's bed showing a sheet, brown in color from what appears to be from dirt and debris on the sheet; -RN B said that the condition of the resident's bed was not acceptable; -RN B pulled the bedding off the corner of the bed and left it laying in the middle of the resident's bed for the CNA to change; -RN B said the condition of the resident's floor next to his/her bed was unacceptable; (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-RN B said the three dry, dark brown objects, formed like a sausage but with cracks on the surface, under the resident's bed appeared to be human feces. -RN B said that he/she was not aware of the resident ever resisting having his/her bedding changed; -The resident came into his/her room while RN B was pulling back the covers on his/her bed and the resident did not appear to be bothered by this. During an interview on 08/30/24, at 1:28 P.M., the Admissions Nurse said the following: -The housekeeping department is short staffed; -The housekeepers are responsible for cleaning three halls, 400, 500, 600 (unit) and management is responsible for cleaning halls 100, 200, 300; -The facility is not as clean as it should be. During interviews on 08/29/24, at 2:25 P.M., and on 08/30/24, at 6:00 P.M., the Maintenance/Housekeeping Supervisor said the nursing staff were cleaning rooms on the unit due to housekeeping being short staffed. The nursing staff were responsible for cleaning up bodily fluids. Housekeeping is not responsible for changing residents bedding. During an interview on 08/30/24, at 3:55 P.M., the MDS Coordinator said the following: -The resident's bedding should be changed every shower day and as needed; -Nursing staff are responsible for changing resident's bedding. During an interview on 08/30/24, at 6:56 P.M., the Director of Nursing (DON) said the following: -Aides on the night shift are responsible for cleaning the unit; -The aides should be sweeping and mopping; -The nursing staff are responsible for cleaning up bodily fluids and feces. During an interview on 08/30/24, at 7:52 P.M., the Administrator said the following: -The nursing staff working on the unit were responsible for cleaning the unit at this time; -The nursing staff are responsible for cleaning up bodily fluids and feces. MO00240384, MO00240390

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48534 Based on record review and interview, the facility failed to maintain a comprehensive person-centered care plan for all residents when staff failed to update the care plan for one resident (Resident #2) to include new information on communicating with the resident effectively when the resident returned from the hospital and failed to ensure all staff were aware of the change. The facility's census was 110. Review of the facility's policy titled, Comprehensive Person-Centered Care Plan, last reviewed 10/23/19, showed the following: -Each resident will have a person-centered plan of care to identify problems, needs strengths, preferences, and goals that will identify how the interdisciplinary team will provide care; -Comprehensive Person Centered Care Plan (CCP) contains services provided, preference, ability and goals for admission, desired outcomes, and care level guidelines; -Kardex is part of the comprehensive care plan and is used as a tool to make staff aware of the resident's daily care needs; -The CCP shall be fully developed within 7 days after completion of the admission Minimum Data Set (MDS - a federally mandated assessment completed by facility staff) assessment; -For each problem, need, or strength a resident-centered measurable goal is developed; -Staff approaches are to be developed for each problems/strength/need. Assigned disciplines will be identified to carry out the intervention; -The CCP can be reviewed and/or revised at quarterly intervals in conjunction with the completion of MDS quarterly, significant change, and annual assessments per the RAI manual; -Upon a change in condition, the CCP or baseline care plan will be updated if applicable. The CCP is updated to reflect risk/occurrences with a problem area, including goals, and interventions to reduce the risk occurrence. 1. Review of Resident #2's face sheet (resident's information at a quick glance) showed the following: -admitted [DATE]; -Diagnoses included unspecified intracranial injury with loss of consciousness (damage inflicted to the brain), muscle weakness, and anxiety disorder (worrying constantly and cannot control the worrying). Review of the resident's quarterly MDS, dated [DATE], showed the following information: (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Minimal difficulty in some environments with hearing; -Clear speech, sometimes understands; -Responds adequately to simple, direct communication only; -Severe cognitive impairment. Review of the resident's care plan updated, dated 08/19/24, showed the following: -The resident had a psychosocial well-being problem related to dementia and other diagnoses; -Allow resident to answer questions and to verbalize feelings perceptions and fears; -When conflict arises, remove residents to a calm safe environment and allow to vent/share feelings; -Explain procedures and care. Encourage resident's participation by providing cueing as needed; -Psychiatric/Psychogeriatric consult as directed. Review of the residents nurses' progress notes showed the following: -On 08/14/24, at 1:20 A.M., the resident left facility via emergency medical transport (EMS) for a 96-hour hold; -On 08/20/24, at 4:45 P.M., the Admissions Coordinator noted the resident readmitted to facility. During hospitalization , a behavior was identified. It was determined that the resident was hard of hearing which made communication difficult. It was identified that writing a note to the resident which resulted in him/her reading it and answering or complying with action was successful. The behavior plan will be communicated to the nursing staff for their use. Review of the resident's Patient Health Summary, provided by the hospital, dated 8/20/24, showed the following: -Reason for admission was aggressive behavior, agitation, and cognitive impairment; -Resident was hard of hearing which made communication difficult with resident; -Use a calm reassuring approach. It often takes a while for the resident to process what is being communicated to him/her. Explain all care before and during cares. Staff may need to re-explain to resident what they are doing; -If resident appears agitated, stop what is being done, re-explain to the resident, give him/her a few minutes, and continue with cares; -When redirecting the resident be firm but gentle and use soft reassuring approach; (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Allow resident to have time to express his/her needs and concerns, listen empathetically; -Be aware of the environment and alert for any triggers that may cause aggressive behaviors; -The resident was unable to answer the staff's questions accurately, just shaking his/her head yes for every question asked before the full question was stated; -The staff wrote the question in large print on a piece of paper and the resident read it aloud then answered the question correctly; -The resident's degree of difficulty with hearing explains why he/she was resistive to cares. Review of the resident's care plan on 08/30/24 showed staff did not update the care plan to reflect the recommendations of the hospital including written communication. During an interview on 08/30/24, at 1:28 P.M., the Admission Coordinator said the following: -The MDS Coordinator is responsible for completing care plans and nurses can update care plans as needed; -Each hall has a binder that included the MDS Kardex report for each resident on the hall, the Kardex report showed the care the resident requires; -The MDS Kardex report was updated monthly; -The resident was recently hospitalized ; -The hospital determined that the resident is extremely hard of hearing and the best way to communicate with the resident is to write down questions and the resident will then read question and answer; -He/she shared the new information with nursing staff and provided paper for staff to use. Review of Kardex report for the resident, last updated 03/13/24, showed the resident's hearing was adequate, speech was clear, the resident was usually able to make self understood, and the resident usually understood others. During an interview on 8/30/24, at 3:55 P.M., the MDS Coordinator said the following: -The aides find resident care in the Kardex binder located on every unit; -He/she was responsible for updating the Kardex; -The resident returned from the hospital recently and the hospital determined that the resident was very hard of hearing and writing down questions for the resident was the best way to communicate; -The Interdisciplinary Team was responsible for care plans; (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident's care plan had not been updated with the new information on how to communicate with the resident. During interviews on 08/30/24, at 1:12 P.M., 1:54 P.M., and 2:33 P.M., Certified Nursing Assistant (CNA) F said the following: -If there is an important message regarding a resident a note is taped to the back the unit's storage closet door; -He/she is not aware of a binder on the unit to find/document care for the residents. -The resident was hard of hearing; -To communicate with the resident staff had to get close to the resident's so he/she can hear what is being said; -He/she also used motions to show/explain to the resident what was happening. During an interview on 08/30/24, at 1:56 P.M., Certified Medical Technician (CMT) G said the staff at the hospital determined the resident was hard of hearing and the best way to communicate with him/her was to write questions on paper for the resident to read. During an interview conducted on 08/30/24, at 5:14 P.M., the Social Service Director (SSD) said the following: -The MDS Coordinator was responsible for updating care plans; -New information related to a resident should be updated on the resident's care plan as soon as provided/made aware of. During an interview on 08/30/24, at 6:56 P.M., the Director of Nursing (DON) said the following: -The MDS Coordinator is responsible for initiating care plans. Nurses, admissions, SSD, and dieticians can update the care plans; -Medical records is responsible for updating the Kardex. During an interview on 08/30/24, at 7:52 P.M., the Administrator said the following: -The MDS Coordinator is responsible for care plans; -Nursing can update care plans; -Care plans should be updated as needed and on a quarterly basis. MO00240384

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48534 Based on observation, interview, and record review, the facility failed to ensure staff provided necessary services for all dependent residents to maintain grooming and personal hygiene when staff failed to complete routine attempts to change urine-soaked clothing and complete bathing and/or showering for one resident (Resident #2) . The facility had a census of 110. Review of the facility's policy titled, ADL (activities of daily living) Care Bathing, dated 07/21/22, showed the following: -Nursing staff will assist in bathing residents to promote cleanliness and dignity. The charge nurse will be made aware of residents who refuse bathing; -Ensure bathing area is at a comfortable temperature; -Be gentle and do not rush the procedure. Allow for breaks if needed; -Encourage resident to bathe him/herself and assist as needed; -Assist with dressing/grooming as needed. 1. Review of Resident #2's face sheet (resident's information at a quick glance) showed the following: -admitted [DATE]; -Diagnoses included unspecified intracranial injury with loss of consciousness (damage inflicted to the brain), muscle weakness, and anxiety disorder (worrying constantly and cannot control the worrying). Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 08/07/24, showed the following information: -Severe cognitive impairment; -No physical or verbal behaviors toward others, or other behaviors not directed toward others exhibited; -The resident did not reject evaluation or care including taking medications and ADL assistance; -Required partial/moderate assistance with toileting, lower body dressing, and personal hygiene; -Required supervision or touching assistance with shower/bathing self, upper body dressing. Review of the resident's care plan, last updated 08/19/24, showed the following: (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident had a psychosocial well-being problem related to dementia and other diagnoses; -Staff to explain procedures and care; -Staff to encourage the resident to participate by providing cueing as needed; -Staff to identify self at each interaction. Face the resident when speaking and make eye contact. Reduce any distractions. The resident understands consistent, simple, and direct sentences. Staff to provide the resident with necessary cues and stop and return if agitated; -The resident is resistive to care at times, specifically refusing to bathe and change clothes; -Give the resident clear explanations of all care activities prior to and as they occur during each contact; -When possible, negotiate a time for ADL's so that the resident participates in the decision-making process. Return at the agreed upon time; -If resident resists with ADL's reassure resident, leave and return five to ten minutes later and try again; -Provide consistency in care to promote comfort with ADL's. Maintain consistency in timing of ADL's, caregivers and routine, as much as possible; -Provide resident with opportunities for choice during care provision; -The resident required supervision with showers. He/she was able to perform all task associated with bathing independently to limited assist, but may need cues at times to remember to perform them. Staff to assist the resident to ensure that the resident is completing the tasks. The resident may need more assistance at times. The resident quite often refuses to shower. The staff must re-approach and encourage him/her to bathe, even it is just a sponge bath; -The resident is supervision to independent with dressing. He/she is able to dress self and likes to choose his/her own clothing; -The resident is independent to supervision with personal hygiene. He/she is able to perform all tasks, but at times requires cues to remember to brush hair, wash hands, etc.; -Staff to monitor/document/report to physician as needed any changes, any potential for improvement, reasons for self-care deficit, expected course, and declines in function. Review of the resident's shower sheets, dated 06/01/24 through 08/29/24, showed the following: -On 06/11/24, the resident refused a shower (at least 11 days since last shower attempt). Staff noted reason of fighting CNA; -On 06/27/24, the resident refused shower (16 days after the last shower attempt). Staff noted reason of yelling/trying to hit; (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 07/24/24, the resident refused shower (approximately one month after the last shower attempt.) Staff reason of combative/yelling; -On 08/06/24, the resident refused shower (13 days after the last shower attempt). Staff noted reason of aggressive; -On 08/12/24, the resident refused shower (6 days after the last shower attempt.) Staff noted reason of yelling and hit at CNA; -On 08/26/24, the resident refused shower (14 days after the last shower attempt. Staff noted reason of combative. Observations of the resident, who resided on the special care unit, showed the following: -On 08/29/24, at 9:30 A.M., the resident sat at a table in the dining room. The resident wore a red t-shirt and faded blue jeans. The resident's jeans were wet from the area around the groin and front pockets on the jeans down to the resident's calves on both legs. -On 08/29/24, at 2:37 P.M., the resident walked down the hallway. The resident's jeans were dry. The front left pocket area of the resident's jeans was yellow in color. The resident was wearing the same red t-shirt. -On 08/30/24, at 8:50 A.M., the resident was in bed, covered up from the waist down, wearing the same red t-shirt as the previous day. There was a strong odor of urine in the resident's room. -On 08/30/24, at 10:26 A.M., the resident sat at a table in the dining room. The resident was in the same red t-shirt and faded blue jeans from the previous day. The resident's jeans were wet from his/her waist to his/her knees. The jeans had a line, that ran below the knee on the left leg to the bottom of the jeans, that was yellow in color and appeared to be dry urine. The resident had an odor of urine about him/her. -On 08/30/24, at 2:32 P.M., the resident in the same red t-shirt and jeans. The resident's jeans were wet in the front groin area as the resident was walking outside. -On 08/30/24, at 3:46 P.M., the resident in the same red t-shirt and jeans. The resident's jeans were wet on the inside of both legs from the crotch area to the resident's knees. (During these observations staff did not attempt to assist the resident with changing his/her clothes or to bathe.) Review of the residents nurses' progress notes, dated 06/01/24 through 08/30/24, showed staff did not document attempts to have the resident change his/her clothing or shower/bathe, the resident's refusals, or re-approaches attempted. During an interview on 08/29/24, at 9:31 A.M., Certified Nursing Assistant (CNA) E said the following: -The resident becomes agitated quickly and was resistive to cares; (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Therapy staff would assist with bathing resident when they were available to do so; -There was no way for aides to to chart on residents. Aides relayed information to nurses by word of mouth. During interviews on 08/30/24, at 1:12 P.M. and 1:54 P.M., CNA F said the following: -The resident was hard of hearing; -To communicate with the resident staff had to get close to the resident so he/she could hear what was being said; -He/she also used motions to show/explain to the resident what was happening; -CNA's do not chart on residents; -He/she passed resident information on by reporting to the nurse through phone call or text messaging; -He/she does not attempt to shower the resident; -The only shower he/she knows of the resident receiving was while the resident was sedated in the hospital. During an interview on 08/30/24, at 1:56 P.M., CNA D said the following: -The CNA was a shower aide, but did not assist residents on the unit with showers; -The aide working the unit showers the residents; -The residents should be receiving two showers per week; -The staff should document all shower refusals on the shower sheet and re-approach the resident. During an interview on 08/30/24, at 1:28 P.M., the Admission Coordinator said the following: -Each hall had a binder that the ADL documentation flow sheet for the month where staff document the ADL's performed; -The ADL documentation flow sheet were updated monthly; -The resident responded to some staff better than others; -The resident would swing to hit people when he/she was agitated. During an interview on 08/30/24, at 3:55 P.M., the MDS Coordinator said the following: -He/she was responsible for updating the ADL documentation flow sheets monthly; (continued on next page)

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Springfield Skilled Care Center	2401 West Grand Springfield, MO 65802

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Aides were responsible for documenting when ADL's were completed. During an interview on 08/30/24, at 2:33 P.M., CNA F said that he/she is not aware of a binder on the unit to find/document care for the residents. During an interview on 08/30/24, at 4:01 P.M., Registered Nurse (RN) B said the following: -The CNAs and certified medication techs (CMTs) on the memory care unit did not have access to resident's electronic record, and the nurses had to complete the charting; -The CNA's on the memory care unit know how to provide care for residents through the report received from other staff; -The resident did refuse showers; -The resident had a recent hospital stay, which revealed he/she was hard of hearing. The staff should write out communication with him/her; -The resident will change clothes about two times per week. The staff laid out clothes for him/her, but the resident would sit around in soiled clothes by choice; -The staff should document showers refused by the resident on the shower sheet and attempt to re-approach the resident at a later time. During an interview on 08/30/24, at 6:56 P.M., the Director of Nursing (DON) said the following: -Staff had been educated on completing shower sheets even when a resident refuses a shower; -The shower sheets were given to the nurse to review and pass on to the DON for review; -Staff should document, every shift, in the ADL binder what assistance was provided to the resident in completing the ADL's. During an interview conducted on 08/30/24, at 7:52 P.M., the Administrator said the following: -The resident refused showers on a regular basis; -Therapy services would sometime assist with showering the resident when they were available; -Staff should document all shower attempts and attempts/refusals to have the resident change clothes in the ADL binder and in the resident nurse notes. MO00240384, MO00240390

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 45190 Based on observation, interview, and record review, the facility failed to ensure an environment as free from accident hazards as possible when staff failed to to place the call light in reach of one resident (Resident #1) as care planned for fa fall intervention. The facility census was 110. Review showed the facility did not provide a policy regarding care light accessibility. 1. Review of Resident #1's face sheet (a brief resident profile) showed the following: -admitted [DATE]; -Diagnoses included pyogenic arthritis (bacterial arthritis), schizophrenia (a disorder that affects a person's ability to think, feel and behave clearly), chronic obstructive pulmonary disease (COPD - a group of lung diseases that block airflow and make it difficult to breathe), unspecified fracture of the kneecap closed with routine healing, unspecified abnormalities of gait and mobility, difficulty in walking, unsteadiness on feet, and localization-related (focal) (partial) idiopathic epilepsy (a type of epilepsy that occurs when abnormal neuronal activity is localized to a specific area of the brain). Review of the resident's annual Minimum Data Set (MDS - a federally mandated assessment tool completed by staff), dated 07/30/24, showed the following: -Moderate cognitive impairment; -Required supervision or touch assistance with toileting hygiene, transfers, and bed mobility. Review of the resident's care plan, last revised 08/19/24, showed the following: -At risk for falls as evidenced by de-conditioning, lower extremity wounds, recent illness with increased weakness, and unsteady gate; -Fall related injuries will be minimized through review date; -Staff to anticipate and meet needs, provide education and reminders to call for assistance as needed, and place call light within reach while in room; -On 02/19/24, resident was noted to fall while self-transferring. Staff encouraged resident to ask for assist with transfers and utilize his/her call light. Observation on 08/30/24, beginning at 9:37 A.M. and ending at 12:23 P.M., showed the following: -Strong odor of urine in the resident's room; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Resident sat in wheelchair with liquid dripping from the seat of his/her wheelchair forming a puddle in the floor; -At 10:23 A.M., the Director of Nursing (DON) entered the resident's room and attached the resident's call light to his/her bed while the resident remained across the room in his/her wheelchair; -At 10:27 A.M., Certified Nurse Aide (CNA) A entered the room and asked the resident if he/she was feeling well. CNA said he/she was going to tell the nurse to check on him/her because the resident seemed off; -At 10:30 A.M., CNA A returned to take the resident's vitals; -At 10:33 A.M., Registered Nurse (RN) B entered the room to assess the resident; -At 10:35 A.M., RN B exited the room to call the nurse practitioner. CNA A remained in the resident's room; -At 10:39 A.M., RN B returned to the room with Licensed Practical Nurse (LPN) C. LPN C advised the resident he/she needed to go the hospital for signs of congestive heart failure (CHF - long-term condition that happens when the heart can't pump blood well enough to give the body a normal supply) exacerbation (temporary worsening of a long-term condition that occurs when the heart doesn't function properly) and needed to be changed first due to an incontinent episode; -LPN C said the resident was typically a one-person transfer, but because he/she was so sleepy, they will complete a two person transfer with a gait belt; -At 10:48 A.M., LPN C exited the room to contact the physician; -At 11:14 A.M., three emergency medical services (EMS) workers entered the resident's room; -At 11:29 A.M., EMS exited the room and no staff were in the room with the resident. The resident's call light was in the floor near the headboard and out of reach of the resident; -At 11:34 A.M., housekeeping staff entered the room, cleaned the floor, and exited at approximately 11:44 A. M. The call light remained on the floor and out of reach of the resident; -At 12:05 P.M., the Assistant Director of Nursing (ADON) entered the room. The resident said he/she wanted to cover up, and the ADON exited the room. The call light remained on the floor and out of reach of the resident; -At 12:10 P.M., the ADON returned to the resident's room and briefly assessed him/her and exited the room. The call light remained on the floor and out of reach of the resident; -At 12:23 P.M., the ADON and RN B entered the resident's room assessed the resident and placed the call light and a call bell within reach of the resident. Review of the resident's progress notes showed the following: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 08/30/24, at 11:00 A.M., the DON was notified by charge nurse the resident was not acting like him/herself. The DON entered the resident's room. Assessment completed and DON will contact practitioner; -On 08/30/24, at 11:03 A.M., resident noticed to be very lethargic with edema (swelling) present to bilateral upper and lower extremities. Staff notified provider of vitals and resident's condition with new orders received to transport to the emergency department for evaluation and treatment; -On 08/30/24, 12:15 P.M., the ADON, while rounding on unit, noticed resident in bed. Resident said he/she was cold and would like blankets. After assessment, staff gave resident the call light and confirmed he/she knew how to use it. During an interview on 08/30/24, at 1:40 P.M., CNA A said staff should ensure call lights are always within reach of the residents. The resident required one person assistance to ambulate and transfer; During an interview on 08/30/24, at 12:13 P.M., CNA D said staff should ensure call lights are always within reach of the residents. During an interview on 08/30/24, at 2:37 P.M., LPN C said staff should ensure call lights are always within reach of the residents. The resident has poor safety awareness. During an interview on 08/30/24, at 4:01 P.M., RN B said staff should ensure call lights are always within reach of the residents. During an interview on 08/30/24, at 6:56 P.M., the DON said the following: -She observed the resident's call light on the floor earlier in the day and attached it to the bed; -Staff should ensure call lights are always within reach of the residents; -Staff should check call lights are within reach of residents on rounds; -Staff should perform rounds on residents every two hours and as needed. During an interview on 08/30/24, at 7:54 P.M., the Administrator said staff should ensure call lights are always within reach of the residents. MO00239914, MO00240161

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45190 Based on observation, interview, and record review, the facility staff failed to ensure all residents were free from significant medication errors when staff failed to have a system to accurately document the timely administration of medications per professional standards when staff frequently documented two doses of medications administered at or near the same time and medication administered out of scheduled time frames for one resident (Resident #1), when the facility failed to have a policy related to a liberalized medication administration system, and when the facility failed to train nursing staff on a liberalized medication administration system. The facility census was 104. Review of the facility policy titled, Medication Administration-Preparation and General Guidelines, revised August 2014, showed the following: -Medications are administered in accordance with written orders of the prescriber; -A schedule of routine dose administration times is established by the facility and utilized on the administration records; -Medications are administered within 60 minutes of scheduled time, except before, with, or after meal orders, which are administered based on mealtimes. Unless otherwise specified by the prescriber, routine medications are administered according to the established medication administration schedule for the facility; -Medications designed to be administered over a 24-hour period are scheduled accordingly. In these cases, an order for twice daily, for example, shall be interpreted as every 12 hours; -The individual who administers the medication dose records the administration on the resident's medication administration record (MAR) directly after the medication is given. At the end of each medication pass, the person administering the medications reviews the MAR to ensure necessary doses were administered and documented. In no case should the individual who administered the medications report off-duty without first recording the administration of any medications; -Current medications, except topicals used for treatments, are listed on the MAR; -The resident's MAR is initialed by the person administering the medication, in the space provided under the date, and on the line for that specific medication dose administration. Initials on each MAR are cross referenced to a full signature in the space provided. (The facility policy did not address if the home had a liberalized medication system and what that entailed.) 1. Review of the Resident #1's face sheet showed the following: -admitted [DATE]; (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Diagnoses included metabolic encephalopathy (brain dysfunction caused by a chemical imbalance in the blood due to an underlying condition), exocrine pancreatic insufficiency (inability to properly digest food), non-pressure chronic ulcer of unspecified part of right lower leg with unspecified severity (a wound to the leg commonly due to poor drainage of blood and/or poor blood supply to the legs), anxiety disorder, and bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), and chronic pain syndrome. Review of the resident's care plan, revised 04/30/24, showed the following: -Resident used antipsychotic medications related to disease processes; -Administer antipsychotic medications as ordered by physician and monitor for side effects and effectiveness every shift; -Resident on pain medication related to chronic pain syndrome; -Administer analgesic medications (pain relievers) as ordered by physician and monitor/document side effects and effectiveness every shift; -Resident had a mood problem related to the disease process of bi-polar disorder; -Administer medications as ordered and monitor/document for side effects and effectiveness. Review of the resident's quarterly Minimum Data Set (MDS -a federally mandated assessment tool completed by staff), dated 05/01/24, showed the following: -Cognitively intact; -Resident received opioid and anti-anxiety medication during the look back period. Review of the resident's current Physician Order Sheet (POS) showed an order, dated 02/02/24, for Creon (medication used to treat people who cannot digest food normally) oral capsule delayed release particles 6000-19000 unit, give one capsule by mouth three times a day with meals. Review of the Creon Medication Guide, dated 02/2024, approved by the U.S. Food and Drug Association, showed the following: -Take Creon exactly as the healthcare provider directs; -Do not take more capsules in a day than the number the healthcare provider directs; -Always take Creon with a meal or snack and enough liquid to swallow Creon completely. Review of the resident's June 2024 Medication Administration Audit Report showed the following: -An order, dated 02/02/24, for Creon oral capsule delayed release particles 6000-19000 unit, give one capsule by mouth three times a day with meals. Staff scheduled the medication administration times as 7:00 A.M., 12:00 P.M., and 7:00 P.M.; (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 06/01/24, staff documented the 7:00 A.M. dose of Creon was administered at 11:29 A.M.; -On 06/01/24, staff documented the 12:00 P.M. does of Creon was administered at 11:31 A.M. (Staff administered the 7:00 A.M. and 12:00 P.M. doses two minutes apart.); -On 06/02/24, staff documented the 7:00 A.M. dose of Creon was administered at 12:58 P.M.; -On 06/02/24, staff documented the 12:00 P.M. dose of Creon was administered at 1:02 P.M. (Staff administered the 7:00 A.M. and 12:00 P.M. doses two minutes apart.); -On 06/12/24, staff documented the 7:00 A.M. dose of Creon was administered at 11:04 A.M.; -On 06/12/24, staff documented the 12:00 P.M. dose of Creon was administered at 11:05 A.M. (Staff administered the 7:00 A.M. and 12:00 P.M. doses one minute apart.); -On 06/26/24, staff documented the 7:00 A.M. dose administered at 1:07 P.M.; -On 06/26/24, staff document the 12:00 P.M. dose administered at 1:09 P.M. (Staff administered the 7:00 A.M. and 12:00 P.M. doses two minutes apart.). Review of the resident's July 2024 medication administration audit report showed the following: -An order, dated 02/02/24, for Creon oral capsule delayed release particles 6000-19000 unit, give one capsule by mouth three times a day with meals. Staff scheduled the medication administration times as 7:00 A.M., 12:00 P.M., 7:00 P.M.; -On 07/03/24, staff documented the 7:00 A.M. dose of Creon administered at 12:52 P.M.; -On 07/03/24, staff documented the 12:00 P.M. dose of Creon administered at 12:53 P.M. (Staff administered the 7:00 A.M. and 12:00 P.M. doses one minute apart.). Review of the resident's current POS showed an order, dated 03/04/24, for oxycodone HCl (an extended-release opioid used to relieve severe pain) oral tablet 5 mg, give one tablet by mouth four times a day for osteoarthritis (degenerative joint disease)/leg wounds. (The order did not specify the times of administration.) Review of the oxycodone HCL package insert, dated 09-07-07, showed the following: -The oxycodone HCL is indicated for the management of moderate to severe pain when a continuous, around-the-clock analgesic is needed for an extended period of time; -Do not adjust the dose of oxycodone HCL without consulting the prescribing professional; -Use oxycodone HCL the way the doctor states; -If a dose is missed, take it as soon as possible. If it is almost time for the next dose, skip the missed dose and go back to your regular dosing schedule. Do not take two doses at once unless a doctor directs this. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's June 2024 Medication Administration Audit Report showed the following: -An order, dated 03/04/24, for oxycodone HCl oral tablet 5 mg, give one tablet by mouth four times a day for OA/leg wounds. Staff scheduled administration at 7:00 A.M., 12:00 P.M., 3:00 P.M., at 7:00 P.M.; -On 06/01/24, staff document the 7:00 A.M. dose of oxycodone administered at 11:31 A.M. Review of the resident's Controlled Substance Accountability sheet for oxycodone 5 mg tablet, take one tablet four times daily, showed on 06/01/24, staff signed a dose out at 8:00 A.M. (3 1/2 hours prior to documented administration). Review of the resident's June 2024 Medication Administration Audit Report showed on 06/01/24, staff documented the 12:00 P.M. dose of oxycodone administered at 11:31 A.M. (the same time as the 7:00 A.M. dose). Review of the resident's Controlled Substance Accountability sheet for oxycodone 5 mg tablet, take one tablet four times daily, showed on 06/01/24, staff signed one dose out at 12:00 P.M. (29 minutes after documentation of administration of the dose). Review of the resident's June 2024 Medication Administration Audit Report showed on 06/02/24 staff document the 7:00 A.M. dose of oxycodone administered at 1:01 P.M. Review of the resident's Controlled Substance Accountability Sheet for oxycodone 5 mg tablet, take one tablet four times daily, showed on staff signed one dose out at 8:00 A.M. (five hours before the medication was documented as administered). Review of the resident's June 2024 Medication Administration Audit Report showed on 06/02/24 staff documented the 12:00 P.M. does of oxycodone administered at 1:02 P.M. (one minute after the 7:00 A.M.). Review of the resident's Controlled Substance Accountability Sheet for oxycodone 5 mg tablet, take one tablet four times daily, showed on 06/02/24 staff signed one dose out at 12:00 P.M. (one hour before documented administration). Review of the resident's June 2024 Medication Administration Audit Report showed on 06/02/24 staff documented the 3:00 P.M. dose administered at 7:31 P.M. Review of the resident's Controlled Substance Accountability Sheet for oxycodone 5 mg tablet, take one tablet four times daily, showed staff signed one dose out at 4:00 P.M. (three and on-half hours before documented administration). Review of the resident's June 2024 Medication Administration Audit Report showed on 06/02/24 staff documented the 7:00 P.M. dose administered at 8:28 P.M. (less than one hour after the prior dose was administered). Review of the resident's Controlled Substance Accountability Sheet for oxycodone 5 mg tablet, take one tablet four times daily, showed on 06/02/24 staff signed one dose out at 8:00 P.M. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's June 2024 Medication Administration Audit Report showed on 06/03/24 staff documented the 3:00 P.M. dose of oxycodone administered at 8:12 P.M. (five hours after the scheduled dose time). Review of the resident's Controlled Substance Accountability Sheet for oxycodone 5 mg tablet, take one tablet four times daily, showed on 06/03/24 staff signed one dose out at 4:00 P.M. (over four hours before staff documented administration). Review of the resident's June 2024 Medication Administration Audit Report showed on 06/03/24, staff document the 7:00 P.M. dose of oxycodone was administered at 8:12 P.M. (the same time as the prior dose). Review of the resident's Controlled Substance Accountability Sheet for oxycodone 5 mg tablet, take one tablet four times daily, showed on 06/03/24 staff signed one dose out at 8:00 P.M. Review of the resident's June 2024 Medication Administration Audit Report showed on 06/09/24 staff documented the 3:00 P.M. dose of oxycodone was administered at 8:40 P.M. Review of the resident's Controlled Substance accountability Sheet for oxycodone 5 mg tablet, take one tablet four times daily showed on 06/09/24 staff signed one dose out at 4:00 P.M. (over four hours before documentation of administration of the dose). Review of the resident's June 2024 Medication Administration Audit Report showed the 7:00 P.M. dose of oxycodone administered at 8:40 P.M. (the same time as the 3:00 P.M. dose). Review of the resident's Controlled Substance Accountability Sheet for oxycodone 5 mg tablet, take one tablet four times daily showed on 06/09/24 staff signed one dose out at 8:00 P.M. (40 minutes before documented administration of the medication). Review of the resident's June 2024 Medication Administration Audit Report showed on 06/10/24 staff documented the 3:00 P.M. dose of oxycodone administered at 8:55 P.M Review of the resident's Controlled Substance Accountability Sheet for oxycodone 5 mg tablet, take one tablet four times daily, showed on 06/10/24 staff signed one dose out at 4:00 P.M.(almost five hours before staff documented administration). Review of the resident's June 2024 Medication Administration Audit Report showed on 06/10/24 staff documented the 7:00 P.M. dose of oxycodone administered at 8:56 P.M. (one minute after the 3:00 P.M. dose). Review of the resident's Controlled Substance Accountability Sheet for oxycodone 5 mg tablet, take one tablet four times daily, showed on 06/10/24 staff signed one dose out at 8:00 P.M. (almost one hour before staff documented administration). Review of the resident's June 2024 Medication Administration Audit Report showed on 06/12/24 staff documented the 7:00 A.M. dose of oxycodone administered at 11:05 A.M. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's Controlled Substance Accountability Sheet for oxycodone 5 mg tablet, take one tablet four times daily, showed on 06/12/24 staff signed one dose out at 8:00 A.M. (over three hours prior to documented administration). Review of the resident's June 2024 Medication Administration Audit Report showed on 06/12/24 staff documented the 12:00 P.M. dose of oxycodone administered at 11:05 A.M. (the same time as the 7:00 A.M. dose). Review of the resident's Controlled Substance Accountability Sheet for oxycodone 5 mg tablet, take one tablet four times daily, showed on 06/12/24 staff signed one dose out at 12:00 P.M. (almost one hour after staff documented administration). Review of the resident's June 2024 Medication Administration Audit Report showed on 06/13/24 staff documented the 3:00 P.M. dose administered at 7:18 P.M. Review of the resident's Controlled Substance Accountability Sheet for oxycodone 5 mg tablet, take one tablet four times daily, showed on 06/13/24 staff signed one dose out at 4:00 P.M. (over three hours before staff documented administration). Review of the resident's June 2024 Medication Administration Audit Report showed on 06/13/24 staff documented the 7:00 P.M. dose administered at 7:19 P.M. (one minute after the 3:00 P.M. dose). Review of the resident's Controlled Substance Accountability Sheet for oxycodone 5 mg tablet, take one tablet four times daily, showed on 06/13/24 staff signed one dose out at 8:00 P.M. (approximately 40 minutes after documented administration). Review of the resident's June 2024 Medication Administration Audit Report showed on 06/23/24, staff documented the 3:00 P.M. dose of oxycodone administered at 7:34 P.M Review of the resident's Controlled Substance Accountability Sheet for oxycodone 5 mg tablet, take one tablet four times daily, showed on 06/23/24 staff signed one dose out at 4:00 P.M. (over three hours before staff documented administration). Review of the resident's June 2024 Medication Administration Audit Report showed on 06/23/24 staff documented the 7:00 P.M. dose of oxycodone administered at 8:09 P.M. (approximately one-half hour after the 3:00 P.M. dose). Review of the resident's Controlled Substance Accountability Sheet for oxycodone 5 mg tablet, take one tablet four times daily, oxycodone 5 mg tablet, take one tablet four times daily, showed on 06/23/24 staff signed one dose out at 8:00 P.M. Review of the resident's current POS showed an order, dated 05/03/24, for diazepam (medication used to treat anxiety) oral tablet 5 mg, give one table by mouth four times a day related to anxiety disorder. (The order did not specify the time of administration.) Review of www.drugs.com, dated 2024, showed the following regarding diazepam: -Take diazepam exactly as prescribed by the doctor; (continued on next page)

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	265477	A. Building B. Wing	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Springfield Skilled Care Center	2401 West Grand Springfield, MO 65802

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-If a dose is missed, take the medicine as soon as possible, but skip the missed dose if it is almost time for the next dose. Do not take two doses at one time. Review of the resident's June 2024 Medication Administration Audit Report showed the following: -An order, dated 05/03/24, for, diazepam 5 mg oral tablet give four times a day related to anxiety disorder. Staff scheduled administration at 7:00 A.M., 12:00 P.M., 3:00 P.M., and 7:00 P.M.; -On 06/01/24, staff documented the 7:00 A.M. dose of diazepam administered at 11:31 P.M. Review of the resident's Controlled Substance Accountability Sheet for diazepam 5 mg tablet, take one tablet four times daily, showed on 06/01/24, staff signed a dose out at 8:00 A.M. (3 1/2 hours prior to documented administration). Review of the resident's June 2024 Medication Administration Audit Report showed the following: -On 06/01/24, staff documented the 12:00 P.M. dose of diazepam administered at 11:31 P.M. (the same time as the 7:00 A.M. dose). Review of the resident's Controlled Substance Accountability Sheet for diazepam 5 mg tablet, take one tablet four times daily, showed on 06/01/24, staff signed a dose out at 12:00 P.M. (29 minutes after documentation of administration of dose). Review of the resident's June 2024 Medication Administration Audit Report showed on 06/02/24, staff documented the 7:00 A.M. dose of diazepam administered at 12:58 P.M. Review of the resident's Controlled Substance Accountability Sheet for diazepam 5 mg tablet, take one tablet four times daily, showed on 06/02/24, staff signed a dose out at 8:00 A.M. (4 hours and 58 minutes prior to documented administration). Review of the resident's June 2024 Medication Administration Audit Report showed on 06/02/24, staff documented the 12:00 P.M. dose of diazepam administered at 1:02 P.M. (four minutes after the 7:00 A.M. dose). Review of the resident's Controlled Substance Accountability Sheet for diazepam 5 mg tablet, take one tablet four times daily, showed on 06/02/24, staff signed a dose out at 12:00 P.M. (one hour and two minutes prior to documented administration). Review of the resident's June 2024 Medication Administration Audit Report showed on 06/02/24, staff documented the 3:00 P.M. dose of diazepam administered at 7:31 P.M. Review of the resident's Controlled Substance Accountability Sheet for diazepam 5 mg tablet, take one tablet four times daily, showed on 06/02/24, staff signed a dose out at 4:00 P.M. (3 hours and 1/2 hours prior to documented administration). Review of the resident's June 2024 Medication Administration Audit Report showed on 06/02/24, staff documented the 7:00 P.M. dose of diazepam administered at 8:28 P.M. (less than one hour after the prior dose was administered). (continued on next page)

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's controlled substance accountability sheet for diazepam 5 mg tablet, take one tablet four times daily, showed on 06/02/24, staff signed a dose out at 8:00 P.M. Review of the resident's June 2024 Medication Administration Audit Report showed on 06/03/24, staff documented the 3:00 P.M. dose of diazepam administered at 8:12 P.M. (five hours after the scheduled dose time). Review of the resident's Controlled Substance Accountability Sheet for diazepam 5 mg tablet, take one tablet four times daily, showed on 06/03/24, staff signed a dose out at 4:00 P.M. (over four hours before staff documented administration). Review of the resident's June 2024 Medication Administration Audit Report showed on 06/03/24, staff documented the 7:00 P.M. dose of diazepam administered at 8:12 P.M. (the same time as the prior dose). Review of the resident's Controlled Substance Accountability Sheet for diazepam 5 mg tablet, take one tablet four times daily, showed on 06/03/24, staff signed a dose out at 8:00 P.M. Review of the resident's June 2024 Medication Administration Audit Report showed on 06/09/24, staff documented the 3:00 P.M. dose of diazepam administered at 8:40 P.M. (over four hours after the scheduled dose time). Review of the resident's Controlled Substance Accountability Sheet for diazepam 5 mg tablet, take one tablet four times daily, showed on 06/09/24, staff signed a dose out at 4:00 P.M. (over four hours before staff documented administration). Review of the resident's June 2024 Medication Administration Audit Report showed on 06/09/24, staff documented the 7:00 P.M. dose of diazepam administered at 8:40 P.M. (the same time as the prior dose). Review of the resident's Controlled Substance Accountability Sheet for diazepam 5 mg tablet, take one tablet four times daily, showed on 06/09/24, staff signed a dose out at 8:00 P.M. Review of the resident's June 2024 Medication Administration Audit Report showed on 06/10/24, staff documented the 3:00 P.M. dose of diazepam administered at 8:55 P.M. (almost five hours after the scheduled dose time). Review of the resident's Controlled Substance Accountability Sheet for diazepam 5 mg tablet, take one tablet four times daily, showed on 06/10/24, staff signed a dose out at 4:00 P.M. (almost five hours before staff documented administration). Review of the resident's June 2024 Medication Administration Audit Report showed on 06/10/24, staff documented the 7:00 P.M. dose of diazepam administered at 8:56 P.M. (one minute after the 3:00 P.M. dose). Review of the resident's Controlled Substance Accountability Sheet for diazepam 5 mg tablet, take one tablet four times daily, showed on 06/10/24, staff signed a dose out at 8:00 P.M. (almost one hour before staff documented administration). (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's June 2024 Medication Administration Audit Report showed on 06/12/24, staff documented the 7:00 A.M. dose of diazepam administered at 11:04 A.M. Review of the resident's Controlled Substance Accountability Sheet for diazepam 5 mg tablet, take one tablet four times daily, showed on 06/12/24, staff signed a dose out at 8:00 A.M. (over three hours before staff documented administration). Review of the resident's June 2024 Medication Administration Audit Report showed on 06/12/24, staff documented the 12:00 P.M. dose of diazepam administered at 11:05 A.M. (one minute after the 7:00 A.M. dose). Review of the resident's Controlled Substance Accountability Sheet for diazepam 5 mg tablet, take one tablet four times daily, showed on 06/12/24, staff signed a dose out at 12:00 P.M. (over three hours before staff documented administration). Review of the resident's June 2024 Medication Administration Audit Report showed on 06/13/24, staff documented the 3:00 P.M. dose of diazepam administered at 7:18 P.M. (almost five hours after the scheduled dose time). Review of the resident's Controlled Substance Accountability Sheet for diazepam 5 mg tablet, take one tablet four times daily, showed on 06/13/24, staff signed a dose out at 4:00 P.M. (over three hours before staff documented administration). Review of the resident's June 2024 Medication Administration Audit Report showed on 06/13/24, staff documented the 7:00 P.M. dose of diazepam administered at 7:19 P.M. (one minute after the 3:00 P.M. dose). Review of the resident's Controlled Substance Accountability Sheet for diazepam 5 mg tablet, take one tablet four times daily, showed on 06/13/24, staff signed a dose out at 8:00 P.M. (approximately 40 minutes after documented administration). Review of the resident's June 2024 Medication Administration Audit Report showed on 06/19/24, staff documented the 3:00 P.M. dose of diazepam administered at 9:40 P.M. (almost five hours after the scheduled dose time). Review of the resident's controlled substance accountability sheet for diazepam 5 mg tablet, take one tablet four times daily, showed entry was not legible. Review of the resident's June 2024 Medication Administration Audit Report showed on 06/19/24, staff documented the 7:00 P.M. dose of diazepam administered at 9:41 P.M. (one minute after the 3:00 P.M. dose). Review of the resident's controlled substance accountability sheet for diazepam 5 mg tablet, take one tablet four times daily, showed entry was not legible. Review of the resident's June 2024 Medication Administration Audit Report showed on 06/23/24, staff documented the 3:00 P.M. dose of diazepam administered at 7:33 P.M. (almost five hours after the scheduled dose time). (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's Controlled Substance Accountability Sheet for diazepam 5 mg tablet, take one tablet four times daily, showed on 06/23/24, staff signed a dose out at 4:00 P.M. (over three 1/2 hours before staff documented administration). Review of the resident's June 2024 Medication Administration Audit Report showed on 06/23/24, staff documented the 7:00 P.M. dose of diazepam administered at 8:09 P.M. (approximately 30 minutes after the 3:00 P.M. dose). Review of the resident's Controlled Substance Accountability Sheet for diazepam 5 mg tablet, take one tablet four times daily, showed on 06/23/24, staff signed a dose out at 8:00 P.M. Review of the resident's June 2024 Medication Administration Audit Report showed on 06/26/24, staff documented the 3:00 P.M. dose of diazepam administered at 7:18 P.M. (almost five hours after the scheduled dose time). Review of the resident's Controlled Substance Accountability Sheet for diazepam 5 mg tablet, take one tablet four times daily, showed on 06/26/24, staff signed a dose out at 4:00 P.M. (over three hours before staff documented administration). Review of the resident's June 2024 Medication Administration Audit Report showed on 06/26/24, staff documented the 7:00 P.M. dose of diazepam administered at 7:19 P.M. (approximately one minute after the 3:00 P.M. dose). Review of the resident's Controlled Substance Accountability Sheet for diazepam 5 mg tablet, take one tablet four times daily, showed on 06/26/24, staff signed a dose out at 8:00 P.M. Review of the resident's June 2024 Medication Administration Audit Report showed on 06/27/24, staff documented the 3:00 P.M. dose of diazepam administered at 9:42 P.M. (over six hours after the scheduled dose time). Review of the resident's Controlled Substance Accountability Sheet for diazepam 5 mg tablet, take one tablet four times daily, showed on 06/27/24, staff signed a dose out at 4:00 P.M. (over five hours before staff documented administration). Review of the resident's June 2024 Medication Administration Audit Report showed on 06/27/24, staff documented the 7:00 P.M. dose of diazepam administered at 9:42 P.M. (the same time as the 3:00 P.M. dose). Review of the resident's Controlled Substance Accountability Sheet for diazepam 5 mg tablet, take one tablet four times daily, showed on 06/27/24, staff signed a dose out at 8:00 P.M. (over one hour prior to staff documented administration). Review of the resident's June 2024 Medication Administration Audit Report showed on 06/29/24, staff documented the 3:00 P.M. dose of diazepam administered at 8:39 P.M. (over five hours after the scheduled dose time). (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's Controlled Substance Accountability Sheet for diazepam 5 mg tablet, take one tablet four times daily, showed on 06/29/24, staff signed a dose out at 4:00 P.M. (over four hours before staff documented administration). Review of the resident's June 2024 Medication Administration Audit Report showed on 06/29/24, staff documented the 7:00 P.M. dose of diazepam administered at 8:39 P.M. (the same time as the 3:00 P.M. dose). Review of the resident's Controlled Substance Accountability Sheet for diazepam 5 mg tablet, take one tablet four times daily, showed on 06/29/24, staff signed a dose out at 8:00 P.M. (over 30 minutes before staff documented administration). Review of the resident's June 2024 Medication Administration Audit Report showed on 06/30/24, staff documented the 3:00 P.M. dose of diazepam administered at 6:50 P.M. (almost four hours after the scheduled dose time). Review of the resident's Controlled Substance Accountability Sheet for diazepam 5 mg tablet, take one tablet four times daily, showed on 06/30/24, staff signed a dose out at 4:00 P.M. (almost three hours before staff documented administration). Review of the resident's June 2024 Medication Administration Audit Report showed on 06/30/24, staff documented the 7:00 P.M. dose of diazepam administered at 6:52 P.M. (two minutes after the 3:00 P.M. dose). Review of the resident's Controlled Substance Accountability Sheet for diazepam 5 mg tablet, take one tablet four times daily, showed on 06/30/24, staff signed a dose out at 8:00 P.M. (over one hour after staff documented administration). Review of the resident's current POS showed an order, dated 02/25/24, for gabapentin (medication used to treat nerve pain) capsule 100 mg, give three capsules by mouth three times a day related to chronic pain syndrome, two capsules make 200 mg. (The order did not specify order times.) Review of www.drugs.com, 08/22/23, showed the following regarding gapapentin: -Take gabapentin exactly as prescribed by the doctor; -if a dose in missed, take the medicine as soon possible, but skip the missed dose if it is almost time for the next dose. Do not take two doses at one time. Review of the resident's June 2024 Medication Administration Audit Report showed the following: -An order, dated 02/25/24, for gabapentin capsule 100 mg, give three capsules by mouth three times a day related to chronic pain syndrome, two capsules make 200 mg. Staff scheduled doses at 7:00 A.M., 12:00 P. M., and 7:00 P.M.; -On 06/01/24, staff documented the 7:00 A.M. dose of gabapentin administered at 11:31 A.M .; (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 06/01/24, staff documented the 12:00 P.M. dose of gabapentin administered at 11:31 A.M. (the same time as the 7:00 A.M. dose); -On 06/02/24, staff documented the 7:00 A.M. dose of gabapentin administered at 1:01 P.M.; -On 06/02/24, staff documented the 12:00 P.M. dose of gabapentin administered at 1:01 P.M. (the same time as the 7:00 A.M. dose). Review of the resident's current POS showed the prior order for gabapentin discontinued on 06/05/24 and a new order, dated 06/05/24, for gabapentin capsule 100 mg, give three capsules by mouth three times a day related to chronic pain syndrome, two capsules to make 200 mg. (The order did not specify times of administration.) Review of the resident's June 2024 Medication Administration Audit Report showed the following: -An order, dated 06/05/24, for gabapentin capsule 100 mg, gabapentin capsule 100 mg, give three capsules by mouth three times a day related to chronic pain syndrome, two capsules to make 200 mg. Staff scheduled doses at 7:00 A.M., 12:00 P.M., 7:00 P.M.; -On 06/12/24, staff documented the 7:00 A.M. dose of gabapentin administered at 11:04 A.M.; -On 06/12/24, staff documented the 12:00 P.M. dose of gabapentin administered at 11:05 A.M. (one minute after the 7:00 A.M. dose). Review of the resident's current POS showed the prior order for gabapentin discontinued on 06/23/24 and a new order, dated 06/23/24, for gabapentin capsule 100 mg, give three capsules by mouth three times a day related to chronic pain syndrome, two capsules to make 300 mg. (The order incorrectly states two capsules are 300 mg instead of 200 mg.) Review of the resident's June 2024 Medication Administration Audit report showed the following: -An order, dated 06/23/24, for gabapentin capsule 100 mg, give three capsules by mouth three times a day related to chronic pain syndrome, two capsules to make 300 mg. Staff scheduled doses at 7:00 A.M., 12:00 P.M., and 7:00 P.M.; -On 06/26/24, staff documented the 7:00 A.M. dose of gabapentin administered at 1:08 P.M.; -On 06/26/24, staff documented the 12:00 P.M. dose of gabapentin by mouth three times at 1:10 P.M. (two minutes after the 7:00 A.M. dose.) Review of the resident's July 2024 Medication Administration Audit Report showed the following: -An order, dated 06/23/24, for gabapentin capsule 100 mg, give three capsules by mouth three times a day related [TRUNCATED]

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45190 Based on observation, interview, and record review, the facility failed to implement an effective infection control program when staff failed to clean urine on a resident's floor in a timely manner, stepped in the urine and walked through the facility without the cleaning of shoes, and left a resident's bare feet in a urine puddle for one resident (Resident #1). Staff also failed to clean the blood pressure monitor between making contact with the floor and using on one resident (Resident #1). The facility census was 110. Review of the facility policy's entitled, Blood/Body Fluid Spill, dated 07/21/22, showed the following: -The facility will clean and disinfect blood/bodily fluid spills following a two-step method; -This task is the responsibility of housekeeping, environmental services, and the Administrator; -Staff should clean spills in resident areas as soon as possible; -Staff should wash hands and wear appropriate PPE (personal protective equipment); -Staff should confine the spill and wipe it up immediately with absorbent (paper) towels, cloths, or absorbent granules (if available) that are spread over the spill to solidify the blood or body fluid and dispose in infectious waste; -Staff should clean and disinfect and not use combined detergent/disinfectant product; -Staff should use intermediate level product; -Staff should remove PPE and dispose in trash and complete hand hygiene. Review showed the facility did not provide a policy related to cleaning of medical equipment. 1. Review of Resident #1's face sheet (a brief resident profile) showed the following: -admitted [DATE]; -Diagnoses included retention of urine. Review of the resident's annual Minimum Data Set (MDS-a federally mandated assessment tool completed by staff), dated 07/30/24, showed the following: -Moderate cognitive impairment; -Uses a wheelchair; -Required supervision or touch assistance with toileting hygiene, transfers, and bed mobility; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Frequently incontinent of bladder and bowel. Review of the resident's current physician order sheet showed the following: -An order, dated 04/01/24, for Multidrug-Resistant Organisms (MDRO) Enhanced Barrier Precautions (a strategy to reduce the spread of MDRO in long-term care facilities); -An order, dated 08/29/24, for Bactrim DS (an antiinfective medication) tablet 800-160 milligram (mg), give one tablet by mouth two times a day for UTI (urinary tract infection) for seven days. Observations and interviews on 08/30/24, beginning at 9:37 A.M. and ending at 11:34 A.M., showed the following: -A strong odor of urine was present; -The resident sat in a wheelchair with liquid dripping from the seat of the wheelchair forming a puddle in the floor. The resident wore a t-shirt and pajama pants and had bare feet; -At 10:23 A.M., the Director of Nursing (DON) entered the resident's room and spoke to the resident while liquid continued to drip from the seat of his/her wheelchair to the floor. The DON's shoes touched the fluid in the floor. She assisted the resident in readjusting in the wheelchair and locked his/her brakes, which moved the wheelchair to a position where the resident's bare feet sat in the puddle of liquid. The DON exited the room at 10:27 A.M., without addressing the liquid puddle in the floor, the resident's bare feet sitting in the liquid, or cleaning the bottom of his/her shoes; -At 10:28 A.M., Certified Nurse Assistant (CNA) A entered the resident's room and squatted down to talk to the resident, placing his/her shoes in the puddle. He/she exited the room at 10:30 A.M., after telling the resident he/she was going to have him/her checked out because he/she seemed off. The CNA did not clean the bottom of his/her shoes; -At 10:30 A.M., CNA A returned with equipment to take the resident's vitals, stepped in the liquid puddle. and stood in the liquid puddle while taking the resident's vitals. CNA dropped the portable blood pressure monitor and cuff on the floor near the liquid puddle; -At 10:33 A.M., Registered Nurse (RN) A entered the resident's room, stepped in the liquid puddle, and attempted to obtain the resident's blood pressure without cleaning the equipment after it had been dropped on the floor. The resident's bare feet continued to be sitting in the liquid puddle; -CNA A and RN B did not address the liquid puddle or attempt to clean it; -At 10:35 A.M., RN B exited the room without cleaning the bottom of his/her shoes; -At 10:39 A.M., RN B returned to the room with Licensed Practical Nurse (LPN) C, and both donned gown and gloves. LPN C advised the resident he/she needed to go the hospital and needed to be changed first due to an incontinent episode. LPN C advised RN B the liquid on the floor needed to be cleaned and then housekeeping would need to sanitize; -RN B said the resident is always incontinent of bladder; (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-RN B and LPN C transferred the resident to the bed walking in the liquid puddle and spreading it on the floor and closed the curtain; -RN B said the resident was soaked in the crotch area and down his/her legs; -At 10:48 A.M., LPN C exited the room to contact the physician and notify housekeeping to clean the room and did not clean the bottom of his/her shoes; -RN B said he/she did not notice all the liquid in the floor and CNA A did not advise him/her the portable blood pressure monitor had been dropped on the floor; -At 10:58 A.M., CNA A entered the room and RN B asked him/her to get a towel to clean up the urine in the floor. He/she left the room briefly and returned with towels and plastic bags; -RN B wiped the urine off the floor with the towels and put them in a large plastic bag along with the resident's clothing, and bed pad and CNA A exited the resident's room with the bag; -At 11:05 A.M., the DON entered the room, donned a gown and gloves, and stepped in the area where the urine had been wiped up with towels, but not sanitized. She said she was told the resident was incontinent while she was in the room, but she did not observe the incontinence; -At 11:31 A.M., the Activities Director pushed the house keeping cart outside the room and said she was told house keeping needed to immediately clean the urine on the floor of the resident's room. A staff member from house keeping began cleaning the room at approximately 11:34 A.M. During an interview on 08/30/24, at 1:40 P.M., CNA A said the following: -Staff should clean blood pressure monitors with sanitary wipes after contact with the floor; -He/she observed and smelled the puddle of urine under the resident's wheelchair, but was unaware he/she stepped in the urine; -He/she did not address the urine in the floor due to obtaining vitals and notifying a nurse of his/her condition. During an interview on 08/30/24, at 2:37 P.M., LPN C said the following: -He/she observed the liquid puddle on the floor under the resident's wheelchair and the strong odor of urine, which is why he/she changed the resident and notified housekeeping to clean up; -Staff should use bleach wipes on the bottom of shoes after stepping in urine. It is not considered best practices to walk around the facility after stepping in urine; -Staff should clean equipment such as blood pressure monitors with an appropriate wipe after contact with the floor; During an interview on 08/30/24, at 4:01 P.M., RN B said the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265477	A. Building B. Wing	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Springfield Skilled Care Center	2401 West Grand Springfield, MO 65802

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Staff should clean urine from the floor as soon as possible and should not walk out of room without cleaning shoes after stepping in urine; -He/she did not notice the puddle of urine on the resident's floor or the odor; -He/she could smell the strong odor of urine on the resident's pants when changing him/her and the pants were wet on the backside and the groin creases; -A resident's bare feet should never be touching urine; it is an infection control issue. During an interview on 08/30/24, at 6:56 P.M., the DON said the following: -Residents should not have puddles of urine in the floor; -Staff should clean the blood pressure monitor after contact with the floor; -He/she did not notice the strong odor of urine in the resident's room or the puddle of urine in the floor; -She did not clean her shoes after stepping in urine and walking in the building; -Nurses clean bodily fluids and housekeeping sanitizes; the resident's floor should have been sanitized. During an interview on 08/30/24, at 7:54 P.M., the Administrator said the following: -Staff should provide incontinent care every two hours and as needed; -There should be no puddles of urine in the floor, staff should notice a resident dripping urine in the floor and should avoid tracking urine in the building; -Medical staff should clean urine from the floor and housekeeping then sanitizes; -Staff should clean the blood pressure monitor after contact with the floor. MO00240390