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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265477 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 10/07/2024 |
| NAME OF PROVIDER OR SUPPLIER Springfield Skilled Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 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) |
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| <p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45176</p> <p>Based on interview and record review, the facility failed to ensure all residents were treated with dignity and respect at all times when one staff member (Licensed Practical Nurse (LPN F)) raised his/her voice at one resident (Resident #1) and told the resident he/she could lose the right to smoke after a fall. The facility census was 106.</p> <p>Review of the facility's policy titles (Resident Rights), dated April 2023, showed the facility staff shall treat residents with kindness, respect, and dignity and ensure resident rights are being following.</p> <p>1. Review of Resident #1's face sheet showed the following:</p> <ul style="list-style-type: none"> -admitted [DATE]; -Diagnoses included metabolic encephalopathy (brain dysfunction caused by a chemical imbalance in the blood that affects brain chemistry), personal history of traumatic brain injury (external force or blow to the head causing temporary or permanent brain dysfunction), acute kidney failure, cognitive communication deficit (difficulty with communication caused by impaired cognitive processes), schizoaffective disorder (mental health problem where you experience psychosis as well as mood symptoms), weakness, and unsteadiness. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 07/17/24, showed the resident had moderate cognitive impairment. Review of the resident's care plan, revised on 09/24/24, showed the following information: <ul style="list-style-type: none"> -Resident had history of falls. -Staff to educate resident to use call light and wait for staff to assist. -Staff to be sure call lights in reach, assist, and ensure proper footwear; -Resident smoked. <p>(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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Review of a written statement completed by LPN F, dated 09/30/24, showed the following:</p> <ul style="list-style-type: none"> -LPN F was leaving the locked unit as residents were going outside to smoke; -The resident was walking crooked and shuffling his/her feet while staring at LPN F; -LPN F told the resident to watch where he/she was going and when the resident turned around he/she tripped over the table; -Certified Nurse's Aide (CNA) A tried to catch the resident by his/her shirt, but staff was not able to keep the resident from falling; -LPN F went to check on the resident and make sure the resident was okay; -LPN F used both hands to pick the resident up off from the floor; -LPN F told the resident he/she had to slow down and stay off the floor if he/she wanted to go smoke. <p>During an interview on 10/04/24, at 3:30 P.M., LPN F said the following:</p> <ul style="list-style-type: none"> -On 09/30/24, around 3:30 P.M. to 4:30 P.M., he/she was completing blood-sugar checks; -The resident was late to smoke and he/she and CNA A were coming out the unit door; -CNA A was in front of the resident. The resident tends to be inappropriate. LPN F told the resident to quit staring at his/her butt and pick up his/her feet and not shuffle when he/she walks; -The resident fell over the table. CNA A grabbed for the resident's shirt in an attempt to prevent the fall, but the resident fell on the floor; -He/she asked the resident if he/she was okay and the resident said he/she was fine and wanted to go smoke; -After the resident was up, LPN F told the resident he/she needed to pay attention and stay on his/her feet or the resident wasn't going to get to smoke. He/she probably shouldn't have said that as he/she doesn't make that decision. <p>Review of a written statement completed by Certified Medication Technician (CMT) G, dated 09/30/24, showed the following:</p> <ul style="list-style-type: none"> -He/she was taking residents on the unit to smoke in the court yard; -CMT G heard a loud thud, turned around, and opened the door to the unit; -LPN F assisted the resident off the floor; <p>(continued on next page)</p> | | |

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| <p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>-When the resident was on his/her feet, LPN F screamed in the resident's face, if you can't fucking walk right, then you're not fucking smoking at all.</p> <p>During an interview on 10/04/24, at 3:43 P.M., CMT G said the following:</p> <p>-On Sunday 09/29/24, about 3:30 P.M., he/she was taking residents out to smoke;</p> <p>-The resident had been unsteady on his/her feet and had prior falls;</p> <p>-CNA A and LPN F were walking the resident out to smoke;</p> <p>-He/she heard the door from the unit open and then while the resident was walking out, he/she collapsed;</p> <p>-LPN F said if he/she couldn't fucking walk right, he/she had no business fucking going outside to smoke.</p> <p>Review of a written statement completed by CNA A, undated, showed the following:</p> <p>-CNA A was leading the resident out to the smoke area. The resident was walking a little behind the aide;</p> <p>-CNA A held the smoke area door open and heard someone yelling and then heard a thud;</p> <p>-CNA A turned around and saw the resident hit/fall onto a small table and then hit the ground;</p> <p>-LPN F walked up assisted the resident up;</p> <p>-CNA A remembered LPN F being upset and saying to the resident, if he/she does not stop falling, he/she won't be allowed to go smoke.</p> <p>During interviews on 10/04/24, at 10:07 A.M. and 3:07 P.M., CNA A said the following:</p> <p>-On 09/30/24, around 4:00 P.M., he/she was beside the resident escorting the resident to smoke;</p> <p>-CNA A grabbed the door to go out to the smoke area and he/she heard a crash behind him/her;</p> <p>-The resident had fallen into the wall, hit the table, and then fell to the floor;</p> <p>-LPN A was a ways away, but he/she screamed God damit, knock the falls off, he/she is sick of this and tired of the paperwork because it's the third or fourth fall.</p> <p>-LPN F also told the resident if the resident didn't stop the falling, he/she wouldn't be smoking.</p> <p>During an interview on 10/04/24, at 1:42 P.M., CNA B, said the following:</p> <p>-It is not appropriate to curse at a resident;</p> <p>(continued on next page)</p> |

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| <p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>-The resident has inappropriate behaviors and LPN F is stern with the resident. The LPN tells the resident to not talk that way or behave that way.</p> <p>During an interview on 10/04/24, at 2:55 P.M., CNA E said the following:</p> <p>-It would not be appropriate to curse at a resident;</p> <p>-He/she would tell the charge nurse if he/she witnessed staff treat a resident disrespectfully.</p> <p>During an interview on 10/07/24, at 9:56 A.M., CNA J said cursing at a resident is not acceptable and he/she would report it to the nurse.</p> <p>During an interview on 10/07/24, at 10:03 A.M., LPN K, said if he/she witnessed staff cursing, he/she would report it to the Director of Nursing (DON).</p> <p>During an interview on 10/07/24, at 1:35 P.M., the DON said if a staff witnesses an employee cursing at a resident, he/she would expect the staff to report it to the charge nurse, DON or the Administrator;</p> <p>During an interview on 10/07/24, at 2:45 P.M., the Administrator said concerns related to treatment of residents by staff should be reported.</p> <p>MO00242882</p> | | |

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| <p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45176</p> <p>Based on observation, interview, and record review, the facility failed to ensure sufficient staff present to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of residents when there was insufficient staff to answer call lights in a timely manner for four residents (Resident #2, #3, #4 and #5), in a review of 16 sampled residents. The facility census was 106.</p> <p>Review showed the facility did not provide a policy regarding answering call lights.</p> <p>1. Review of the facility's Resident Council Meeting Minutes, dated 08/15/24, showed residents requested administration to hire more nursing staff.</p> <p>Review of the facility's Resident Council Meeting Minutes, dated 09/19/24, showed one resident complained of aides not answering call lights quickly enough.</p> <p>2. Review of the facility census sheet, dated for 10/04/24, showed the following:</p> <ul style="list-style-type: none"> -600 hall had 16 residents; -500 hall had 26 residents; -400 hall had 30 residents; -300 hall had 15 residents; -200 hall had 15 residents; -100 hall had 8 residents. <p>Review of the facility's staffing sheet, dated 10/04/24, showed the following:</p> <ul style="list-style-type: none"> -Day shift, from 7:00 A.M. to 7:00 P.M. Two nurses with one nurse coming in at 3:00 P.M. Two certified med techs (CMT) on duty. Two certified nurse aides (CNA) each covering 100 hall, 200 hall, and 300 hall. One CNA each covering 400 hall, 500 hall, and 600 hall; -Night shift, from 7:00 P.M. to 7:00 A.M. Two nurses and two CMTs on duty. One CNA beginning at 7:00 P. M. and another aide beginning at 11:00 P.M. on 100 hall, 200 hall, an 300 hall. One aide on 400 hall, 500 hall, and 600 hall. <p>3. Review of Resident #2's face sheet showed the following:</p> <ul style="list-style-type: none"> -admitted [DATE]; <p>(continued on next page)</p> | | |

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| <p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>-Diagnosis included respiratory failure (lungs cannot get enough oxygen), diabetes (body doesn't produce enough insulin), hemiplegia (paralysis or weakness on one side), and anxiety (feelings of fear or dread);</p> <p>-Resided on 300 Hall.</p> <p>Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment tool used by facility staff), dated 07/12/24, showed the following:</p> <p>-Moderate cognitive impairment;</p> <p>-Makes self understood</p> <p>-Usually understands others;</p> <p>-Required substantial assistance for toileting hygiene, showers, lower body dressing roll left to right, and lying to sitting;</p> <p>-Impaired upper and lower extremity on one side;</p> <p>-Did not walk;</p> <p>-Used a wheelchair;</p> <p>-Always incontinent of bladder and frequently incontinent of bowel.</p> <p>Review of the resident's care plan, revision date of 08/19/24, showed the following:</p> <p>-Resident required assistance with assistance with activities of daily living (ADLs). The resident required two assist with showers, bed mobility, dressing, toilet use, and transfers;</p> <p>-Staff to encourage use of call bell for assistance.</p> <p>Interviews and observations on 10/04/24, beginning at 9:16 A.M., showed the following:</p> <p>-The call light was on outside of the resident's room;</p> <p>-The resident said within the last week, he/she had been left in a wet brief for four hours. He/she turned his/her light on and when staff finally came to answer, they said the light wasn't working;</p> <p>-The resident said he/she also tried to call out for help to get changed but no one assisted Him/her;</p> <p>-The resident said he/she was wet and needed to be changed;</p> <p>-He/she is incontinent of the bladder and is dependent upon staff for all of his/her cares;</p> <p>(continued on next page)</p> | | |

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| <p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>-At 9:25 A.M., an employee from the business office came into speak with the resident and then left;</p> <p>-At 9:30 A.M., two staff came from the opposite direction and went into a room and then back up the hall. One staff went into the break room, just opposite the resident's room;</p> <p>-At 9:43 A.M., two aides came up the hall with a bag, went into a room and then went back down the hall in the opposite direction of the resident's room;</p> <p>-At 9:53 A.M., CMT C came out with his/her med cart and the resident said his/her name and the CMT said something and continued up the hall;</p> <p>-At 9:54 A.M., the Family Nurse Practitioner (FNP) went into the resident's room and asked the resident how he/she is feeling, and if the resident needed help. The resident acknowledged He/she needed help;</p> <p>-At 9:57 A.M., 41 minutes after the call light was observed to be on, CNA A went into the resident's room to provide cares.</p> <p>During an interview on 10/04/24, at 10:11 A.M., CNA A said the following:</p> <p>-He/she doesn't believe there are enough staff to meet the resident's needs;</p> <p>-There is an aide on 400 hall, an aide on 500 hall, and one on 600 hall;</p> <p>-The 100, 200, and 300 halls are the heaviest halls with the census showing a total of 38 residents and there are two CNAs;</p> <p>-There is a problem with staff that are supposed to work 12 hours. They leave early or they don't come in until later and there is a lapse in coverage.</p> <p>4. Review of Resident #'3's face sheet showed the following:</p> <p>-admitted [DATE];</p> <p>-Diagnosis included Parkinson's disease (progressive nervous system disorder), aphasia (affects person's ability to communicate), and unsteadiness on feet;</p> <p>-Resides on 300 hall.</p> <p>Review of the resident's care plan, revision date of 05/10/24, showed resident had bladder incontinence and needed assistance with toileting.</p> <p>Review of the resident's quarterly MDS, dated [DATE], showed the following:</p> <p>-No cognitive impairment;</p> <p>-Usually makes self understood</p> <p>(continued on next page)</p> |

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| <p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>-Usually understands others;</p> <p>-Required partial assistance for toileting hygiene, showers, and personal hygiene;</p> <p>-Did not walk;</p> <p>-Used a wheelchair.</p> <p>During an interview on 10/04/24, at 9:59 A.M., the resident said the following:</p> <p>-It sometimes takes staff a long time to answer the call light;</p> <p>-Two to three weeks ago, he/she put his/her call light on at 9:00 P.M. and the staff did not answer the light until 2:00 A.M.;</p> <p>-He/she usually takes him/herself to the bathroom, but once in bed he/she needed help to change the brief.</p> <p>During an interview on 10/07/24, at 12:24 P.M., CNA L said the resident needs help to get into bed so it takes a long to put him/her in bed and he/she has to wait awhile.</p> <p>5. Review of Resident #4's face sheet showed the following:</p> <p>-admitted [DATE];</p> <p>-Diagnoses included diabetes, chronic pain syndrome, and metabolic encephalopathy (brain dysfunction that occurs when there is an imbalance of chemicals);</p> <p>-Resided on 400 hall.</p> <p>Review of the resident's quarterly MDS, dated [DATE], showed the following:</p> <p>-Moderate cognitive impairment;</p> <p>-Makes self understood</p> <p>-Understands others;</p> <p>-Required substantial assistance for toileting hygiene, showers, lower body dressing, and personal hygiene;</p> <p>-Did not walk;</p> <p>-Used a wheelchair.</p> <p>Review of the resident's care plan, revision date of 09/30/24, showed the following:</p> <p>-At risk for falls. Staff to anticipate and meet resident's needs;</p> <p>(continued on next page)</p> | | |

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| <p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>-Be sure resident's call light is within reach and encourage use for assistance;</p> <p>-Resident needs prompt response to all requests for assistance;</p> <p>-Resident to participate to the fullest extent possible with ADL's;</p> <p>-Encourage use of call bell for assistance.</p> <p>During interviews on 10/04/24, at 11:15 A.M., and on 10/07/24, at 11:56 A.M., the resident said the following:</p> <p>-He/she reported needing assistance with getting off from the toilet, pulling up his/her pants, and toileting hygiene;</p> <p>-Last week he/she put on his/her call light and no one answered for a long time;</p> <p>-He/she began to yell out for help;</p> <p>-Two days ago, on the day shift, he/she was on the toilet for two hours;</p> <p>-He/she began to yell and the admission nurse came in and helped him/her with cares.</p> <p>During an interview on 10/04/24, at 2:07 P.M., CMT C said the resident needed toileting assistance. Staff do encourage the resident to do what he/she can for him/herself, but they have not refused to provide care. He/she likes for call lights to be answered within 5 to 10 minutes.</p> <p>During an interview on 10/04/24, at 3:07 P.M., CNA A said the following:</p> <p>-The other day the resident was on the toilet screaming;</p> <p>-He/she did tell another staff the resident needed help and he/she believed another aide helped the resident in 30- minutes.</p> <p>6. Review of Resident #5's face sheet showed the following:</p> <p>-admitted [DATE];</p> <p>-Diagnosis included diabetes, weakness, dislocation of left hip, dependence on wheelchair, and absence of limb;</p> <p>-Resides on 300 hall.</p> <p>Review of the resident's care plan revision, date of 07/02/24, showed the following:</p> <p>-Resident at risk for falls. Staff to be sure call light is within reach and encourage use for assistance. Resident needs prompt response to all requests;</p> <p>(continued on next page)</p> | | |

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| <p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>-Resident has bladder incontinence, needs assistance with changing soiled under garments and perform peri care, and he/she wears briefs.</p> <p>Review of the resident's quarterly MDS, dated [DATE], showed the following:</p> <ul style="list-style-type: none"> -Moderate cognitive impairment; -Makes self understood -Understands others; -Required substantial assistance for toileting hygiene, showers, upper and lower body dressing and personal hygiene; -Did not walk; -Used a wheelchair; -Always incontinent of bowel and bladder. <p>Review of the resident's care plan, revision date of 09/30/24, showed the following:</p> <ul style="list-style-type: none"> -At risk for falls. Staff to anticipate and meet resident's needs; -Be sure resident's call light is within reach and encourage use for assistance; -Resident needs prompt response to all requests for assistance; -Resident to participate to the fullest extent possible with ADL's; -Encourage use of call bell for assistance. <p>During interviews on 10/04/24, at 10:52 A.M., and on 10/07/24, at 12:40 P.M., the resident said the following:</p> <ul style="list-style-type: none"> -It takes staff a while to answer call lights, sometimes up to an hour; -Staff will come when the resident has his/her call light on and they aren't able to help, but they shut if off and don't come back; -In the past he/she has had to wait 3 1/2 hours to get help; -The facility can't keep help. <p>During an interview on 10/07/24, at 12:24 P.M., CNA L said the the resident was in a wet brief all of the time.</p> <p>(continued on next page)</p> | | |

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| <p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>7. During an interview on 10/04/24, at 1:50 P.M., CNA B said it doesn't take over 10 minutes to answer most call lights, unless there are multiple lights on and other things going on,</p> <p>8. During an interview on 10/04/24, at 2:07 P.M., CMT C said he/she has heard it takes longer to answer call lights over night. He/she is not aware of any residents left wet or soiled.</p> <p>9. During an interview on 10/04/24, at 2:19 P.M., Registered Nurse (RN) D said the following:</p> <ul style="list-style-type: none"> -The facility is understaffed; -They have one aide on 600 hall with 16 residents, one aide on 400 hall with about 25 residents, and two aides on 100, 200 and 300 halls and sometimes a hospitality aide. For all the 106 residents, there are five aides and the one in the memory care unit, 600 must be in the unit at all times. <p>10. During an interview on 10/04/24, at 2:55 P.M., CNA E said the following:</p> <ul style="list-style-type: none"> -He/she is the only aide on 400 Hall from 6:00 A.M., to 6:00 P.M.; -The hall has four residents that require a Hoyer lift (mechanical lift used for non-weight-bearing residents) and one of the residents wants to get up for each meal and go to the dining room; -He/she will go into a room and let the resident know they're helping someone else and sometimes he/she does shut off the call light. <p>11. During an interview on 10/04/24, at 3:30 P.M., Licensed Practical Nurse (LPN) F said the following:</p> <ul style="list-style-type: none"> -Staffing is lacking some days, especially with call ins; -There is usually one aide to each hall, sometimes no one for hall 600 so he/she will cover until someone comes in; -He/she knows residents on 100, 200, and 300 halls have longer wait times during the night as there is one aide after 7:00 P.M. <p>12. During an interview on 10/07/24, at 9:56 A.M., CNA J said the following:</p> <ul style="list-style-type: none"> -He/she is on 500 hall and it's a lighter hall; -He/she usually answers call lights in two minutes; -There are usually three staff on 100, 200 and 300 halls. <p>13. During an interview on 10/07/24, at 10:32 A.M., the MDS Coordinator said the following:</p> <ul style="list-style-type: none"> -He/she is presently doing the staffing schedule; -The staffing and call lights have improved the last few months; <p>(continued on next page)</p> | | |

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

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| <p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>-Days and nights are staffed the same, one aide each on 600, 500 and 400. 100, 200 and 300 halls have two aides.</p> <p>14. During an interview on 10/07/24, at 12:24 P.M., CNA L said the following:</p> <p>-The facility is understaffed;</p> <p>-The 100, 200 and 300 halls usually have two staff, sometimes one and they are heavy halls so they really need three. Lately there has been a float to help;</p> <p>-There is one aide each on 400, 500, and 600 halls;</p> <p>-Often there is a gap on 400 hall so the aide on that hall has to go cover the memory care unit/600 hall from 3:00 P.M., until 7:00 P.M., so that leaves no aide assigned to 400 hall.</p> <p>15. During an interview on 10/07/24, at 1:35 P.M., the Director of Nursing (DON) said the following:</p> <p>-Call lights are being answered timely, however it can be longer depending on if staff are helping another resident;</p> <p>-He/she expects call lights to be answered within 5 to 10 minutes;</p> <p>-They have one aide on 400, one on 500, and one on 600 halls. There are two aides on 100, 200, and 300 halls and sometimes a float. There is a shower aide and CMTs on the halls, however, the CMTs do leave at 11:00 P.M There is also a nurse.</p> <p>16. During an interview on 10/07/24, at 2:45 P.M., the Administrator said he would like to see call lights answered within 5 minutes.</p> <p>MO00242839</p> |

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| <p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45176</p> <p>Based on observation, interview, and record review, the facility failed to ensure sufficient a fully functional call light system for all residents when the call lights for two residents (Resident #2 and #4) did not function properly. The facility census was 106.</p> <p>Review of the Facility's Resident Call System, dated 10/22, showed the following:</p> <ul style="list-style-type: none"> -During rounds nursing an Interdisciplinary Team (IDT) Member will ensure the resident call system is within reach of the resident; -In the event the resident call system is down, call bells will be utilized until power is restored; -The Maintenance Director will complete routine resident call system checks. <p>1. Review of Resident #2's face sheet showed the following:</p> <ul style="list-style-type: none"> -admitted [DATE]; -Diagnoses included respiratory failure (lungs cannot get enough oxygen), diabetes (body doesn't produce enough insulin), hemiplegia (paralysis or weakness on one side), and anxiety (feelings of fear or dread); -Resided on 300 Hall. <p>Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment tool used by facility staff), dated 07/12/24, showed the following:</p> <ul style="list-style-type: none"> -Moderate cognitive impairment; -Makes self understood -Usually understands others; -Required substantial assistance for toileting hygiene, showers, lower body dressing roll left to right, and lying to sitting; -Impaired upper and lower extremity on one side; -Did not walk; -Used a wheelchair; -Always incontinent of bladder and frequently incontinent of bowel. <p>(continued on next page)</p> |

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| <p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Review of the resident's care plan, revision date of 08/19/24, showed the following:</p> <ul style="list-style-type: none"> -Resident required assistance with assistance with activities of daily living (ADLs). The resident required two assist with showers, bed mobility, dressing, toilet use, and transfers; -Staff to encourage use of call bell for assistance. <p>Interviews and observation on 10/04/24, beginning at 9:16 A.M., showed the following:</p> <ul style="list-style-type: none"> -The call light was on outside of the resident's room; -The resident said within the last week, he/she had been left in a wet brief for four hours. He/she turned his/her light on and when staff finally came to answer, they said the light wasn't working; -The resident said he/she also tried to call out for help to get changed, but no one assisted him/her; -He/she does have a bell, but it's located in a drawer out of his/her reach; -The resident said he/she was wet and needed to be changed; -He/she is incontinent of the bladder and is dependent upon staff for all of his/her cares; -At 9:25 A.M., an employee from the business office came into speak with the resident and then left. There was observed one other call light on next door to the resident's; -At 9:30 A.M., two staff came from the opposite direction and went into a room and then back up the hall. One staff went into the break room, which was opposite the resident's room; -At 9:35 A.M., the resident's light was not showing on at the nurses' station, only the room next to it. Registered Nurse (RN) D said some call lights are malfunctioning and there isn't a consistent one. Staff are doing rounds more to ensure residents needs are met. All residents are supposed to have bells to use if they're call light doesn't work; -At 9:43 A.M., two aides came up the hall with a bag, went into a room and then went back down the hall in the opposite direction of the resident's room; -At 9:53 A.M., Certified Medication Tech (CMT) C came out with his/her med cart and the resident said his/her name and the CMT said something and continued up the hall; -At 9:54 A.M., the Family Nurse Practitioner (FNP) went into the resident's room and asked the resident how he/she is feeling, and if the resident needed help. The resident acknowledged he/she needed help; -At 9:57 A.M., (41 minutes after the call light was observed to be on outside of the resident's room), CNA A went into the resident's room to provide cares. <p>(continued on next page)</p> |

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| <p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>During an interview on 10/04/24, at 10:07 A.M., Hospitality Aide M said there are two rooms on 300 hall with call lights that stuck on sometimes, but they shut off at the nurses' station. There is a box in front of the nurses' station that shows the rooms that need assistance.</p> <p>During an interview on 10/04/24, at 10:11 A.M., Certified Nurse Aide (CNA) A said some of the call lights have electrical issues. All of the residents have a bell for backup.</p> <p>2. Review of Resident #4's face sheet showed the following:</p> <ul style="list-style-type: none"> -admitted [DATE]; -Diagnosis included diabetes, chronic pain syndrome, and metabolic encephalopathy (brain dysfunction that occurs when there is an imbalance of chemicals); -Resided on 400 hall. <p>Review of the resident's quarterly MDS, dated [DATE], showed the following:</p> <ul style="list-style-type: none"> -Moderate cognitive impairment; -Makes self understood -Understands others; -Required substantial assistance for toileting hygiene, showers, lower body dressing, and personal hygiene; -Did not walk; -Used a wheelchair. <p>Review of the resident's care plan, revision date of 09/30/24, showed the following:</p> <ul style="list-style-type: none"> -At risk for falls. Staff to anticipate and meet resident's needs; -Staff to be sure resident's call light within reach and encourage use for assistance; -Resident needs prompt response to all requests for assistance; -Encourage use of call bell for assistance. <p>Observations and interviews on 10/04/24, at 11:15 A.M., and on 10/07/24, at 11:56 A.M., the resident said the following:</p> <ul style="list-style-type: none"> -He/she reported needing assistance with getting off from the toilet, pulling up his/her pants, and toileting hygiene; <p>(continued on next page)</p> | | |

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| <p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>-He/she said the bathroom call light sounds at the nurses' station, however, it doesn't light up outside of his/her room;</p> <p>-Observed the call light in the bathroom turned on, however it did not light up outside. It did sound at the nurses' station; ;</p> <p>-Last week he/she put on his/her call light and no one answered for a long time;</p> <p>-Two days ago, on the day shift, he/she was on the toilet for two hours.</p> <p>During an interview on 10/04/24, at 1:50 P.M., CNA B said the resident was able to take him/herself to the bathroom, but needs help with getting off of the toilet and toileting hygiene. The resident's bathroom call light does not light in the hall, but does go off at the desk.</p> <p>During an interview on 10/04/24, at 2:55 P.M., CNA E said the only light that doesn't work on the hall is the resident's bathroom call light. It does sound at the nurses' station loudly, but not at his/her room.</p> <p>3. During an interview on 10/04/24, at 2:19 P.M., RN D said the following:</p> <p>-Certain call lights don't function properly at times. It is not consistent;</p> <p>-All residents have bells and those that have call light issues are more independent;</p> <p>-If they do find a call light not working they let maintenance know and until the light works, they check on the resident more often.</p> <p>4. During an interview on 10/04/24, at 2:44 P.M., the Admission's Nurse said there have been functionality issues with the call lights and when that happens the maintenance person takes care of it. The residents have bells to use.</p> <p>5. During an interview on 10/04/24, at 3:30 P.M., Licensed Practical Nurse (LPN) F said there are some issues with call lights. They may not sound at the nurses' station, but work on the hall, or the other way around. Residents do have call bell.</p> <p>6. During an interview on 10/07/24, at 9:51 A.M., CMT I said he/she knows there have been some issues with calls lights, but when they residents have issues, they repair them.</p> <p>7. During an interview on 10/07/24, at 2:45 P.M., the Administrator said he was not aware of any call lights not working. The ones that were noted are now all working and the entity that put in the new system will be here Wednesday to look at them. Maintenance also does weekly checks on the call light system.</p> <p>MO00242839</p> | | |