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	11/20/2024

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45190 Based on interview and record review, the facility failed to provide a written notice discharge, including the reason for discharge and right to appeal, to all resident upon discharge when the home failed to provide a written discharge notice to one resident (Resident #1) when they refused to accept the resident back to the facility after hospitalization . The facility census was 99. 1. Review of Resident #1's face sheet showed the following: -admitted [DATE]; -Diagnoses included paraplegia (paralysis that affects all or part of the trunk, legs, and pelvic organs), bi-polar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), type II diabetes mellitus (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), dysphagia oropharyngeal phase (difficulty swallowing), cognitive communication deficit, and schizophrenia (disorder that affects a person's ability to think, feel, and behave correctly). Review of the resident's care plan, revised 08/19/24, showed the following: -Active discharge planning to the community after completion of a skilled stay; -Resident will verbalize/communicate an understanding of the discharge plan and describe the desired outcome by the review date; -Establish a pre-discharge plan with the resident/family/caregivers and evaluate progress and revise plan as indicated; -Evaluate and discuss with the resident/family/caregivers the prognosis for independent or assisted living. Identify, discuss, and address limitations, risks, benefits and needs for maximum independence; -Evaluate the resident's motivation to return to the community; (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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Evaluate/record the resident's abilities and strengths, with family, caregivers and interdisciplinary team. Determine gaps in abilities which will affect discharge. Address gaps by community referral to pre-discharge physical therapy/occupational therapy, internal referral or home health services as indicated; -Make arranges with required community resources to support independence post discharge. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment completed by facility staff), dated 8/21/24, showed the following: -Moderately cognitive impairment; -Resident used a wheelchair and required partial to moderate assistance from staff for toilet hygiene and transfers, staff supervision with showering, and substantial assistance with transferring to shower. Review of the resident's progress notes showed the following: -On 10/18/24, at 1:34 A.M., resident signed leave of absence at 1:10 A.M., and had returned inside the building; -On 10/18/24, 3:03 A.M., resident had been very talkative and active during the evening. Resident has been in/out of building numerous times. Resident now sitting on the toilet stating he/she can't stand, incontinent of bladder, heart pounding, and screaming to go to the hospital. Resident is self-responsible party. Staff notified emergency medical services (EMS) and paperwork obtained. Resident transported to hospital with EMS and his/her request for evaluation; -On 10/18/24, at 9:17 A.M., (late entry) Social Service Director (SSD) was in front office when yellow cab driver came to window and stated he/she needed someone to get this man/woman out of my car. SSD asked cab driver to pull around to skilled side of building and SSD would meet him/her there. Upon arriving to skilled side the resident refused to get out of cab until SSD contacted his/her family member for payment for cab. SSD explained that SSD had spoken to his/her family member earlier that day and that his/her family member was currently at work. SSD stated she would pay for cab. Resident continued to refuse to get out of cab until SSD paid driver along with $10 tip. SSD asked the resident several times to get out of cab as cab driver had another ride waiting on him. Resident finally got out of cab and then would not move away from cab door. SSD had to move resident's wheelchair away from cab as cab driver was pulling away. SSD called hospital emergency room regarding not contacting the facility for the resident's return. ER said that they had provided resident with a cab voucher, but he/she refused to go with that cab and was being difficult. Resident stated that he/she had cash to pay for the cab, so they allowed him/her to schedule his/her own ride. -On 10/18/24, at 8:21 P.M., the resident returned from the hospital emergency room with no new orders. He/she continued behaviors of rapid speech, restlessness, agitation and not following medication protocol. The resident left per EMS for different hospital for psychiatric evaluation; -On 10/18/24, at 8:22 P.M., clarification of previous behavioral note, the resident returned from hospital on 10/18/24, at 9:00 A.M., with continued behaviors and no new orders. He/she was later transferred the evening of 10/18/24, to a different hospital on a 96-hour hold and was admitted . (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(Staff did not document a written notice of discharge provided to the resident.) Review of the resident's Affidavit in Support of Application for Detention, Evaluation and Treatment/Rehabilitation-Admission for 96 Hours, dated 10/18/24, showed the following: -Resident had been escalating and was currently in a manic state in which he/she was refusing all prescribed medication including anti-psychotic medications; -Resident was engaging in risky behavior without concern for his/her well being or well-being of others; -Resident had a history of self-harm; -Physician agreed resident needed a 96-hour hold for medication adjustment. Review of the resident's record showed staff did not have a copy of a written discharge notice sent to the resident or a resident representative. Review of the resident's electronic record showed staff did not document a discharge notice completed or given to the resident on or after 10/18/24. During interviews on 11/20/24, at 2:09 A.M. and 5:08 P.M., the SSD said the following: -Nurses start transfers when sending a resident out to the hospital; -The resident signs the paperwork if able; -The resident would leave and say he/she was going to a family member's house, but did not and would come back and demand to go to the hospital. The resident would then return and refuse to come inside the facility; -The resident returned from the hospital in a cab and refused to get out of the cab; -On 10/18/24, the physician said to complete an affidavit to send to the resident to the hospital for a 96-hour hold; -The facility does emergency discharges when the facility is unable to meet a resident's needs; -The resident was not safe at the facility and was not allowed to return due to behaviors; -She did not know why the facility did not issue a written emergency discharge for the resident; -She did not not know the facility policy regarding emergency discharges. During an interview on 11/20/24, at 2:46 P.M., Registered Nurse (RN) A said the following: -He/she was the admissions nurse; (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident was at the hospital and the hospital social worker called on the Thursday prior to discharge from the hospital on 11/13/24, and asked him/her to come to the hospital before Monday to assess the resident. He/she went to the hospital and assessed the resident the next day, Friday. The resident could not follow train of thought, was manic with more of a flat affect. He/she was unable to talk to the social worker until Monday and expressed the resident was not well enough to return. The social worker from the hospital called the next day (Tuesday) and said he/she had a great conversation with the resident, and he/she seemed normal. He/she asked the social worker for a progress note and to come and assess the resident again. The hospital social worker said the resident would be discharged on Thursday or Friday. He/she advised the hospital social worker the facility would not be accepting the resident back. The hospital sent the resident back in a cab on 11/13/24. He/she went out to the cab and explained to the resident he/she was not coming back to the facility and the cab to the resident back to the hospital. During an interview on 11/20/24, at 5:45 P.M., the Administrator and Licensed Practical Nurse (LPN) C said the following: -Transfers are completed when a resident is sent out to the hospital. The resident signs if he/she is able; -Residents are re-evaluated following a return from a 96-hour hold; -Staff issues immediate discharges for behaviors and all involved will sign the paperwork, including guardian, ombudsman, physician, and resident; -Staff at the hospital were advised the resident did not want to return to the facility; -The resident told the Administrator, he/she did not want to return. He would have let the resident in the building if he/she had wanted to return; -There was no documentation of the resident not wanting to return to the facility; -The facility did not complete and give any type of discharge notice to the resident. MO00245098