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	01/13/2026

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 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to manage his or her financial affairs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to honor residents' request for funds as soon as possible, but no later than the same day for amounts of $50.00 for Medicaid residents, for two residents (Resident #1 and Resident #2). The facility census was 106.Review of the undated facility's policy titled Business Office-Resident Trust Fund Policy and Procedure, showed the following: -Residents of a Skilled Nursing Center are to have their funds managed and personal spending money available to them. Regardless of payment source, residents have the right to choose whether or not to open a Resident Trust Fund account with the Center. If the choice to open a trust fund account is made, the resident has the right to have their money safeguarded and accounted for by the Center. The residents have the right to have any funds deposited with the center, in an interest-bearing account, according to state guidelines. All resident account balances over $50.00 will accrue interest. The Administrator ultimately will be responsible for the oversight and management of resident funds;-For the benefit of its residents, the Center shall provide a Resident Trust Cash Box and a separate bonded interest bearing bank account for all residents who choose to have their personal money safeguarded and managed by the Center. The Center will have, at all times, a current copy of the surety bond, per state regulations, to cover resident trustfunds. The resident or their legal guardian are the only ones who can designate what the monies are spent on and have the right to request their Resident Trust Fund Ledger at any time;-The Center will honor any request of resident funds $50.00 ($100.00 for Medicare residents) or less that same day and any request of resident funds over $50.00 ($100.00 for Medicare residents) within 3 business days of the request. 1. Review of Resident #1's face sheet, a document that gives a patient's information at a quick glance, showed the following: -The resident admitted on [DATE];-The resident was his/her own responsible party. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated comprehensive assessment instrument completed by facility staff, dated 01/01/26, showed the following: -The resident was cognitively intact. During an interview on 01/06/26, at 12:17 P.M., the resident said: -He/she kept his/her funds in a resident trust account;-He/she had to go to the facility bank twice to get his/her $50.00;-He/she could get $35.00 one day and the remaining $15.00 the next day;-If he/she wanted to withdraw $50.00, he/she had to fill out a form for the Business Office Manager (BOM) and wait two days;-He/she was not denied access to his/her funds unless he/she requested more than $35.00 and then had to fill out a form and wait for the money. 2. Review of Resident #2's face sheet showed the following: -The resident admitted on [DATE];-The resident was his/her own responsible party. Review of the resident's quarterly MDS, dated [DATE], showed the following: -The resident was cognitively intact. During an interview on 01/07/26, at 9:17 A.M., the resident said: -He/she received $50.00 per month;-If he/she needed more than $35.00, he/she had to fill out a request form 48 hours in advance;-If he/she needed the full $50.00 without advance notice, he/she did not know what he/she would do. 3. During an interview on 01/06/26, at 3:08 P.M., the Business Office Assistant (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265477	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/13/2026

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	said the following: -If a resident had money in their resident trust account, they were allowed to withdraw $35.00 per day;-He/she did not know why residents could only withdraw $35.00 a day;-If a resident wanted to withdraw more than $35.00, they filled out a request form 48 hours prior to needing the money;-He/she did not deny residents money unless they did not have money in their account. 4. During interviews on 01/06/26, at 2:52 P.M. and 01/07/26, at 11:32 A.M., the BOM said the following: -Residents withdrew money from the window by the activity room and can withdraw up to $35.00 a day;-If residents wanted more than $35.00, they filled out a request form and he/she went to the bank to get the money because the facility's cash box could not hold that much money;-He/she did not deny residents money from their trust unless the resident did not have money in their account;-The facility could only hold $2,000.00 in the cash box and if they allowed residents to pull their full $50.00 out on the first of the month, the facility would run out of money in the cash box fast;-He/she did not think $35.00 a day was regulation, but it was the facility's policy due to being a liability to have so much money in the facility;-If a resident did not have two days to wait for their money and the facility had the money on hand, the resident could get their full $50.00. 5. During an interview on 01/07/26, at 1:24 P.M., the Assistant Director of Nursing (ADON) said he/she believed if a resident wanted to withdraw their $50.00 at once, the facility should allow that. 6. During an interview on 01/07/26, at 4:30 P.M., the Director of Nursing (DON) said if a resident received $50.00 a month, they should be able to withdraw in one lump sum. 7. During an interview on 01/13/26, at 3:16 P.M., the Administrator said: -When residents came to the facility bank, they could not give every resident their full $50.00;-She was told by her corporation if the facility was the payee for the resident's social security, the facility was only allowed to give the resident $10.00 a day and that social security rules were followed over Centers for Medicare and Medicaid Services (CMS) guidelines. Complaint #2706058

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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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow wound physician recommendations to obtain wound cultures and an X-Ray for one resident (Resident #7) with a vascular wound to his/her left shin. The facility census was 106.Review of the facility policy titled, Notification of a Change in Condition, revised on 02/06/25, showed:-The attending physician/nurse practitioner will be notified of a change in the resident's condition;-Responsibility: All licensed nursing personnel, nursing administration, and Director of Nursing (DON). 1. Review of Resident # 7 face sheet showed:-admission date of 9/27/25;-Diagnoses of traumatic ischemia (lack of sufficient blood flow) of muscle, peripheral artery disease (when narrowing of the arteries leads to reduced blood flow to the limbs) and diabetes mellitus, type II. Review of the resident's admission Minimum Data Set (MDS), a federally mandated comprehensive assessment tool completed by facility staff, dated 10/06/25, showed:-admitted to the facility on [DATE] from the hospital;-Cognitively intact;-Functional limitation in range of motion to both lower extremities;-Required set up/clean up assistance with eating;-Dependent on staff for assistance with transfers, personal hygiene, and toileting;-Required substantial/maximal assistance with showering;-Always incontinent of bowel and bladder;-Diagnoses of traumatic ischemia of muscle, deep vein thrombosis (blood clot), and peripheral arterial disease;-Presence of venous or arterial ulcer;-Currently on antibiotic therapy. Review of the resident's care plan, created on 11/03/25, showed, the following:-Resident had impairment of skin integrity to the left shin, infected arterial wound;-Perform treatment to wound per current treatment order;-Assess wound for signs/symptoms of infection with each dressing change/treatment;-Report positive findings of redness, warmth, swelling, increased drainage, or increased pain;-Report progress/wound healing to the physician, with any changes or lack of response to treatment Review of the resident's [NAME] wound report, dated 10/02/25, showed the following:-Infected wound to the resident's left shin;-Wound present on admission;-Open area measured 13.0 centimeters (cm) long by 6.5 cm wide by 0.3 cm deep with odor, erythema (redness), moderate amount of purulent drainage (thick, milky discharge), and 100% slough (stringy, yellowish-tan, dead tissue);-Recommendations: Obtain deep wound culture of left shin wound.Review of the resident's medical record showed staff did not document regarding wound culture results. Review of the resident's weekly [NAME] wound report, dated 10/09/25, 10/16/25, and 10/23/25 showed recommendation: wound culture.Review of the resident's medical record showed staff did not document regarding wound culture results. Review of the resident's weekly [NAME] wound report, dated 10/30/25, showed:-Recommendations: X-ray of left shin for evaluation of osteomyelitis (serious infection of the bone) and deep wound culture.Review of the resident's medical record showed staff did not document regarding wound culture results or X-Ray of left shin results. Review of the resident's [NAME] weekly wound report, dated 11/14/25, showed:-A different physician completed the weekly wound report;-Assessment showed left leg arterial wound size 23.0 cm long by 5.0 cm wide by 1.2 cm deep with undermining (tissue destruction under intact skin at the edge of a wound) of 2.5 cm at 12 o'clock;-The wound had black necrotic (dry, leathery, dead) tissue covering 10% of wound bed, devitalized necrotic (any dead tissue, can be moist) tissue covering 70% of wound bed, and 20 % skin;-Progress: Not at goal due to infection and peripheral vascular disease, odor of pseudomonas (a specific type of bacterial infection) in the wound;-Recommendation: Referral to vascular surgeon;-Wound culture and X-ray of left shin for evaluation of osteomyelitis.Review of the resident's medical record showed staff did not document regarding wound culture results or X-Ray of left shin results. Review of the resident's [NAME] weekly wound report, dated 11/21/25, showed recommendation: X-ray of the left leg.Review of the resident's medical (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	record showed staff did not document regarding X-Ray of left shin results. Review of the resident's progress note, dated 11/24/25, showed the Nurse Practitioner P documented the following:-Resident is pending vascular surgeon for consideration of below the knee amputation. Resident reports pain in the left lower extremity is not well managed. Review of the resident's [NAME] weekly wound report, dated 11/26/25, showed:-Recommendations: Culture of wound and X-ray of the left leg;-Awaiting surgical evaluation for possible amputation.Review of the resident's medical record showed staff did not document regarding wound culture results or X-Ray of left shin results. Review of the resident's progress note, dated 11/26/25 at 5:47 P.M. showed the wound nurse, Registered Nurse (RN) J documented the following:-On 11/26/25, the full-thickness arterial wound on the resident's left lower leg was evaluated and remains at goal with palliation focus. The wound measured 23.1 cm long by 6.0 cm wide by 0.5 cm deep with undermining, moderate purulent drainage, and mixed necrotic tissue. A surgical excisional debridement was performed removing 62.37 cm squared of devitalized tissue to viable level with bleeding observed, followed by daily treatment, offloading, and close monitoring;-Diagnostic studies including X-ray, deep wound cultures are pending, and the resident continues under off-loading and repositioning protocols with vascular surgical consult pending for potential below or above knee amputation.Review of the resident's medical record showed staff did not document regarding wound culture results or X-Ray of left shin results. Review of the resident's progress note, dated 11/28/25 (Friday) at 9:34 A.M., showed Registered Nurse (RN) O documented the following:-The resident's wound has declined in condition. The wound had more drainage and foul odor. The resident had more pain during the dressing change. The resident was followed by a wound physician. Will inform the physician of changes on Monday (12/01/25). Review of the resident's progress note, dated 11/29/25 at 10:42 A.M., showed Licensed Practical Nurse (LPN) D documented the following:- The resident had nausea/vomiting and other change in condition;-Vital signs included a blood pressure of 160/80 millimeters/Mercury (mm/Hg) (normal range 900/60-120/80 mm/Hg), heart rate of 113 beats per minute (bpm) (normal range 60-100 bpm), respirations of 20 breaths/minute (normal range 12-18 breaths/minute), and a temperature of 98.8 degrees Fahrenheit (F) (normal range 97.8-99.1 degrees F);-Resident was lethargic, had nausea/vomiting (nausea medication given with effective results), chills, shaking, and wound had excessive green purulent drainage from left shin wound with foul smell. The physician recommended sending the resident to the emergency department. Review of the resident's progress note, dated 11/29/25 at 11:37 A.M., showed Registered Nurse (RN) O documented the following:-The resident's wound dressing was saturated. During the dressing change, an increase in foul smelling drainage and the drainage was pooling up in the wound bed. The wound showed signs of infection, was warm to touch, painful, and had excessive drainage. The resident showed signs of sepsis, felt warm to touch, shaking, and increased respirations. The nurse informed the charge nurse of his/her assessment and findings. Review of the resident's Hospital History and Physical, dated 11/29/25, showed:-Extensive past medical history including left lower extremity claudication (clot) status post mechanical cannulation of the left anterior and posterior tibial arteries and thrombectomy (clot removal) of the popliteal artery (supplies blood to the knee, lower leg, and foot) on 9/21/25;-Diagnoses included Type 2 diabetes mellitus, atrial fibrillation (irregular heart rhythm), high blood pressure, chronic non-pressure skin ulcerations, nicotine dependence;-Recently discharged from the hospital on 9/27/25 after treatment for urinary tract infection and bacteremia (presence of bacteria in the blood stream), treated with antibiotics;-Presented with ongoing leg infection and fever;- Resident informed the ER he/she has a bad wound on his/her leg that has gotten worse and was painful; - The resident will likely need amputation of his/her left leg and resident said he/she was aware and ready for that;-Assessment/plan: Ulcer (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	of left lower extremity with necrosis of muscle, infected skin ulcer with fat layer exposed, cellulitis (infection of the tissue) of left lower leg, fever. peripheral vascular disease:-Plan: Extensive anterior left lower extremity wound with infection, connective tissue visible with areas of necrosis, likely multifactorial in the setting of status post claudication, thrombectomy, diabetes, delayed wound healing in the setting of cigarette nicotine dependence. Emergency physician discussed with vascular surgeon. May proceed with left lower extremity amputation. During interviews on 1/12/26 at 11:45 A.M. and at 2:49 P.M., the wound nurse, Registered Nurse (RN) J said the following:-He/she rounded with the [NAME] wound physician weekly;-Once the wound physician completed his/her after visit summary, the wound nurse reviewed the wound physician notes for any changes/new orders;-He/she placed any new or changed orders in the resident's electronic medical record, in the physician orders section;-He/she checked with the resident's primary care physician if he/she modified any order;-He/she notified the primary care physician of any changes in condition of the wound;-If the resident experienced a significant change in condition, he/she would send the physician a message via secure text message and then document the change of communication and physician response in the progress note;-The resident was admitted to the facility on [DATE] with 3 large wounds to his/her anterior (front of) left leg. The wound was necrotic with bubbling pus/drainage on admission and had an odor;-The wound physician started seeing the resident weekly shortly after admission;-The facility had completed the treatments to the leg as ordered, but the wound physician said the resident's leg would require amputation despite the treatment.-Initially, when the wound physician discussed the probable need for amputation with the resident, the resident did not want to have his/her leg amputated. During an interview on 1/12/26 at 3:45 P.M., Licensed Practical Nurse (LPN) C said the following:-He/she checked the resident's October 2025 treatment administration record (TAR) which showed an order dated 10/02/25 to obtain a culture of the resident's leg wound;-The nurse stated he/she documented NA and after checking the resident's progress notes;-He/she could not locate any culture swabs to obtain the resident's leg wound culture;-The nurse said on 10/03/25, the physician started the resident on an antibiotic, Ciprofloxacin for a wound infection to the left shin;-He/she did not obtain a wound culture of the left shin. During an interview on 01/12/25 at 2:30 PM., the resident said he/she had wounds to his/her legs and feet prior to admission. Due to diabetic neuropathy, he/she had decreased feeling in his/her legs and feet. The resident said that he/she had to have his/her left leg amputated above the knee. During a phone interview on 1/13/26 at 11:00 A.M., Registered Nurse (RN) O said the following:-On Friday (11/28/25) and Saturday (11/29/25), the resident's wound was covered in moist eschar, yellow-green drainage, and a foul odor;-He/she did not call the resident's physician on 11/28/25, because he/she thought the wound physician was aware of what was going on with the resident's leg wound;-He/She thought the resident's leg condition could wait until Monday (12/01/25) and a nurse could notify the physician about the changes to the condition of the resident's leg at that time;-He/she did not recall a wound culture order on the resident. During a phone interview on 01/13/26 at 1:15 P.M., the [NAME] Wound Physician, said the following:-From the first time seeing the wound, the physician felt the wound was beyond what localized treatment would address;-He/she made a suggestion to the resident that the resident would probably require an amputation of his/her leg;-The physician did not feel that failures in the resident's care led to the infection and subsequent amputation, but rather felt the amputation was unavoidable. During an interview on 01/13/26 at 1:24 P.M., LPN D said the following:-He/she evaluated the resident on Saturday (11/29/25) and sent the resident out to the hospital;-RN O reported changes in the resident's condition, he/she did not see the resident's leg, but rather went with what RN O said about the condition of the resident;-He/she recalled the (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	previous wound physician thought the resident would require an amputation;-He/she was not aware of any wound culture. During an interview on 01/13/26 at 2:26 P.M., the Director of Nursing (DON) said the following:-The nurse should have notified the physician or nurse practitioner of changes to the resident's leg wound on 11/28/25 via secure messaging or should have called the on-call physician;-If a wound culture was ordered, the nurse should have obtained the wound culture within the same shift;-He/she believed the wound physician may have collected the culture, but the DON was unable to find any results of the wound culture;-He/she was unable to find an X-ray of the resident's left shin;-The wound nurse should review the [NAME] wound notes when finalized and place any recommended orders in the electronic health record or notify the nurse on duty if X-rays or labs were needed;-The facility should have the wound culture and X-ray results in the resident's medical record. During an interview on 1/13/26 at 3:16 P.M., the Administrator said the following:-If the resident's wound culture order was on the TAR, the nurses should have attempted to obtain the culture. If the nurse was unable to obtain the culture, the nurse should have notified the physician and documented in a progress note;-The facility should obtain wound cultures and X-rays within 24 hours of receiving the order to complete;-The wound nurse should review all [NAME] wound physician's recommendations and notify the primary care physician of the recommendations. Complaint 2714772

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, the facility failed to maintain an effective system of reconciliation for all controlled substances, when nursing staff failed to maintain signature sheets for counting of the controlled substances at the beginning and end of each nurse shift for two of two nurse carts. These two carts were referred to as Skilled 1 and Skilled 2 which contained all as needed (PRN) controlled resident medications. The facility census was 106. 1. Review of the controlled medication books located on each cart showed no sheet for nurses to sign when counting controlled medications at the beginning and end of each shift.Observation on 01/13/26 at 2:00 P.M., showed two medication carts located inside the locked nurse station. During an interview on 1/13/26 at 2:00 P.M., Licensed Practical Nurse (LPN) B said the following:-The two carts located in the nurse station are the nurse carts and are referred to as Skilled 1 and Skilled 2 carts;-The carts contain all PRN controlled medications for the residents;-At the beginning and end of each shift the off going and oncoming nurses count the quantity of each controlled medication and the total number of controlled medication packages;-The nurses do not sign to confirm the shift count;-He/She has worked at the facility for approximately 3 months and has never signed to confirm the beginning and end of shift count.During an interview on 1/13/26 at 2:05 P.M., Licensed Practical Nurse (LPN) C said the following:-At the beginning and end of each shift, the off going and oncoming nurses count the quantity of each controlled medication and the total number of controlled medication packages;-The nurses do not sign to confirm the shift count;-He/She has worked at the facility for approximately 6 months and has never signed to confirm the beginning and end of shift count.During an interview on 1/13/26 at 2:26 P.M., the Director of Nursing said the following:-Nurses should count all controlled medications in each card or package and the total number of controlled medication packages in their assigned cart at the beginning and end of each shift;-The nurses should sign the signature sheet to confirm they have counted and the count was correct;-He/she was not aware the nurses were not signing to confirm the controlled medication count. He/she had not been auditing to ensure nurses were signing to confirm the narcotic count each shift. During an interview on 1/13/26 at 3:16 P.M., the Administrator said the following:-Nurses should be signing for completion and accuracy of the narcotic count at the beginning and end of each shift.Complaint 2714772

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure staff administered resident medications as ordered by the physician, when during medication administration observation for Residents # 5 and #6, staff made 4 errors out of 27 opportunities for error, resulting in a medication error rate of 6.75%. The facility census was 106.Review of the facility policy titled, Medication Administration-General Guidelines, revised August 2014, showed:-Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have been properly oriented to the facility's medication distribution system (procurement, storage, handling, and administration). The facility has sufficient staff and a medication distribution system to ensure safe administration of medications without unnecessary interruptions;-Five Rights- Right resident, right drug, right dose, right route, and right time, are applied for each medication being administered. A triple check of these rights is recommended at three steps in the process of preparation of a medication for administration: (1) when the medication is selected, (2) when the dose is removed from the container, and finally (3) just after the dose is prepared and the medication put away;-The medication administration record (MAR) is always employed during medication administration. Prior to administration of any medication, the medication and dosage schedule on the resident's MAR are compared with the medication label. If changes in directions, or if there is any other reason to question dosage or directions, the physician's orders are checked for the correct dosage schedule. When a medication order is changed and the current supply can continue to be used, the container should be flagged right away and the order change communicated to the provider pharmacy so that the next supply of the medication is labeled with the current directions.-If a medication with a current, active order cannot be located in the medication cart/drawer, other areas of the medication cart, medication room and facility are searched, if possible. If the medication cannot be located after further investigation, the pharmacy is contacted or medication removed from the emergency kit;-Medications are administered in accordance with written order of the prescriber;-If a dose seems excessive considering the resident's age and condition, or a medication order seems to be unrelated to the resident's current diagnoses or conditions, the nurse should call the provider pharmacy for clarification prior to the administration or the medication or if necessary, contacts the prescriber for clarification. The interaction with pharmacy and/or prescriber and the resulting order clarification are documented in the nursing notes and elsewhere in the medical record as appropriate;-Monitoring of side effects or medication related problems occurs continually, but particularly after medication administration and especially after the first few doses of a new medication;-The individual who administers the medication dose records the administration on the resident's 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;-If a dose of regularly scheduled medication is withheld, refused, not available, or given at a time other than the scheduled time, the space provided on the front of the MAR for that dosage is initialed and circled. An explanatory note is entered on the reverse side of the record. If a vital medication is withheld, refused, or not available the physician is notified. Nursing documents the notification and the physician's response;-If an electronic MAR system is used, specific procedures required for resident identification, identifying medications due at specific times, and documentation or administration, refusal, holding of doses, and dosing parameters (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	such as vital signs and lab values are described in the system's user manual. These procedures should be followed and may differ slightly from the procedures for using paper MARs. 1.Review of Resident #5's face sheet showed:-admitted to the facility on [DATE];-Diagnoses of diabetes mellitus type II, restless leg syndrome, and fibromyalgia (chronic disorder with muscle fatigue, pain, sleep disturbance, and cognitive issues). Review of the resident's current physician order sheet showed:-Order for Rosuvastatin Calcium oral tablet 20 mg. Give one tablet by mouth (po) in the morning for hyperlipidemia (high cholesterol), order dated 10/24/25;-Order for Ropinirole Hydrochloride (HCl) extended release (ER) 4 milligram tablet by mouth. Give one tablet one time a day for diagnosis of restless leg syndrome, order dated 10/29/25. Observation on 1/09/26 at 8:54 A.M., showed CMT G administering the following medications to Resident #5:-Rosuvastatin 20 mg 1 po, staff pulled a 20 mg tablet from a plastic strip of medications and pulled a 20 mg tablet from a bubble pack (both labeled for resident use, both with the same prescription) and placed the 2 tablets into the medication cup for administration, instead of the 1 tablet dose as ordered;-Ropinirole 4 mg 24-hour release, the CMT looked for the medication, but the medication was not available in the medication cart and was not in the emergency kit when that CMT looked. The CMT told the nurse the medication was not available. The nurse said he/she would contact the pharmacist. The medication was not available for administration as ordered;This observation equaled a total of 15 medications administered with 2 medication errors. Review of the resident's January 2026 Medication Administration Record (MAR) showed:-Order for Rosuvastatin Calcium oral tablet 20 mg. Give one tablet by mouth in the morning. Give one tablet in the morning between 7:00 A.M. and 11:00 A.M. for a diagnosis of hyperlipidemia (high cholesterol), order dated 10/24/25;-On 1/07/26, CMT G initialed administration of the Rosuvastatin dose.-Order for Ropinirole Hydrochloride (HCl) extended release (ER) 4 milligram tablet by mouth. Give one tablet one time a day at 8:00 A.M., for a diagnosis of restless leg syndrome, order dated 10/29/25;-On 1/07/26 at 8:00 A.M., CMT G charted ‘NA' (Not administered. See nurse note). Review of the resident's progress notes/nurse notes showed no coinciding note with the date/time/reason for not administering the Ropinirole. 2. Review of Resident #6's face sheet showed:-admitted to the facility on [DATE];-Diagnoses of Insulin dependent diabetes type II and chronic obstructive pulmonary (lung) disease. Review of the resident's physician orders showed:-Advair Diskus (medication used in treatment of lung disease by opening airways) 250/50 micrograms (mcg)/actuation (operation). One inhalation, inhale orally two times per day for COPD, dated 12/06/25.-Prednisone (corticosteroid used to treat severe inflammation, allergies, autoimmune diseases, and certain cancers by suppressing the immune system and reducing swelling) oral tablet 5 milligrams (mg) by mouth in the morning for COPD order dated 12/22/25. Observation and interview on 1/07/26 at 9:26 A.M., showed CMT N, made the following medications errors while administering medications to Resident #6:-Advair Diskus, the CMT looked for but could not locate the inhaler for the resident and stated he/she was going to make sure the medication was ordered from the pharmacy;-Prednisone 5 mg tablet, the CMT said he/she did not have the 5 mg prednisone, but the facility had ordered the medication from the pharmacy and was waiting on delivery of the medication;-Niether of these medications were available for administration as ordered; observation equaled a total of 12 medications administered with 2 medication errors. Review of the resident's January 2026 medication administration showed:-Advair Diskus 250/50 micrograms (mcg)/dose. One inhalation, inhale orally two times per day for COPD, dated ;12/06/25-On 1/07/26, for the 7:00 A.M-11:00 A.M. dose, CMT N documented NA (not administered. See nurse note).Review of the resident's progress notes, dated 1/07/26, showed, medication on order. Review of the resident's January 2026 medication administration showed:-Prednisone oral tablet 5 milligrams (mg) by mouth in the morning for COPD order dated (continued on next page)

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 01/13/2026

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/22/25;-On 1/07/26, for the 6:00 A.M.-11:00 A.M. dose, CMT N documented HD (Hold. See nurse note). Review of the resident's progress notes, dated 1/07/26, showed medications on order. During an interview on 10/7/26 at 9:30 A.M., CMT N said the facility had issues with medication availability. During an interview on 1/07/26 at 3:00 P.M., Certified Medication Technician (CMT) M said the following:-Resident medication availability was an issue at times;-Some of the CMTs did not re-order medications when resident supply ran low;-At times, the pharmacy took longer than expected, up to 2 days or more, to deliver ordered medications;-The facility was in the process of changing to a different pharmacy;-He/she was unsure if the nurses double checked the physician orders to ensure the medication orders were correct. During an interview on 1/07/26 at 3:20 P.M., LPN B said the following:-The facility had an issue with medication availability from the pharmacy;-There were issues with the communication between the pharmacy and the physician for ordering and re-ordering of controlled medication;-These issues caused delays in residents receiving ordered medications timely;-When the physician gave a new order, the nurse should ensure the order is placed correctly into the physician orders the same day. During an interview on 1/07/26 at 12:06 P.M., LPN C said the following:-If a resident did not have an ordered medication, the nurse or CMT should contact the pharmacy and order the medication or pull the medication from the facility's emergency supply;-If a resident's medication was not available at the time of administration, the nurse should call the physician or send the physician a message and ask for a substitution and document the response in a progress note. During an interview on 1/07/26 at 1:05 P.M., CMT F said the following:-Sometimes the pharmacy sends duplicates of the same medications. At times, the pharmacy sent the same medication in a bubble card and in a plastic strip. This happened more often with a new prescription;-He/she said CMTs were not allowed to order medications stat (immediately) from the pharmacy. The CMTs were supposed to notify the nurse when a medication was not available for administration and the nurse would contact the pharmacy;-He/she tried to order the medications enough ahead of time so the resident would not run out of the medication. During an interview on 1/07/26 at 2:25 P.M., the DON said the following:-If a nurse or CMT did not have a resident medication available for administration, the nurse should contact the pharmacy and contact the physician to notify and see what the physician wants the staff to do and document all in a progress note. During an interview on 1/13/26 at 3:16 P.M., the Administrator said the following:-If a CMT could not locate an ordered medication for a resident, he or she should check the back up supply or notify the nurse when the medication was not available;-The nurse should contact the pharmacy and the physician for any needed medication. This should be done timely, within the same shift;-If the nurse had an issue obtaining the medication, or had questions, they should reach out to the DON of Administrator;-If a CMT did not give a medication to a resident, the CMT should document a note, explaining which medication and why the medication was not administered;-The nurse should document the follow up in the progress notes;-Nurses should complete the 5 rights of medication administration as per the facility policy, to ensure residents received the correct dose of each medication. Complaint 2699464, 2707177, 2707414, 2707810, 2712161, and 2714772.

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 01/13/2026

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 0760

Level of Harm - Actual harm

Residents Affected - Few

Ensure that residents are free from significant medication errors.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY Based on observation, interview, and record review, the facility failed to follow physician medication orders and/or medication recommendations resulting in significant medication errors for 4 residents (Resident #3, #4, #1, and #8) when staff transcribed Resident #3's medication order incorrectly for digoxin (a cardiac medication used to treat heart failure and irregular heartbeat, which has a narrow therapeutic range requiring careful monitoring for side effects), resulting in digoxin toxicity (dig tox, a condition resulting from taking too much digoxin causing symptoms like nausea, vomiting, confusion, vision changes, and serious cardiac issues) and hospitalization, when staff transcribed Resident #4's order incorrectly for Coumadin (warfarin, an anticoagulant medication/ blood thinner) resulting in elevated blood levels placing the resident at an increased bleeding risk, when staff failed to address/follow physician recommendations for changes to Resident #1's insulin and blood sugar checks, resulting in staff administering less than the recommended dose of insulin and fewer blood checks, placing the resident at increased risk of hyperglycemia (high blood sugar), and when staff failed to administer Resident #8's psychotropic medications as ordered. The facility census was 106.

Review of the facility policy titled, Admission/readmission Orders, dated 11/01/18, showed:

-Upon admission/readmission, orders for care of the resident are received from attending physician, transcribed onto physician's orders and kept in the medical record;

-Admission/readmission orders are obtained on day of admission in one of the following ways: Physician provides written orders, nurse received orders via telephone, in which case via telephone is indicated by nurse signature;

-Orders are verified on day of admission with the attending physician for accuracy and completeness prior to care rendered;

-All medications and treatments are required to have a diagnosis;

-Orders must be dated and co-signed by a nurse during the admission process and signed by the attending physician within 30 days;

-If original orders are sent to the physician for a signature, a copy must remain in the medical record until the signed form is returned;

-Original admission orders should be retained in the medical record;

-re-admission to the facility after hospitalizations voids all previous orders. Therefore, all orders pertinent to the resident must be verified upon re-admission.

Review of the facility policy titled, Medication Administration-General Guidelines, revised August 2014, showed:

-Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have been properly oriented to the facility's medication distribution system (procurement, storage, handling, and administration). The facility has sufficient staff and a

(continued on next page)

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	265477	A. Building B. Wing	01/13/2026

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 0760 Level of Harm - Actual harm Residents Affected - Few	medication distribution system to ensure safe administration of medications without unnecessary interruptions; -Five Rights-Right resident, right drug, right dose, right route, and right time, are applied for each medication being administered. A triple check of these rights is recommended at three steps in the process of preparation of a medication for administration: (1) when the medication is selected, (2) when the dose is removed from the container, and finally (3) just after the dose is prepared and the medication put away; -The medication administration record (MAR) is always employed during medication administration. Prior to administration of any medication, the medication and dosage schedule on the resident's MAR are compared with the medication label. If changes in directions, or if there is any other reason to question dosage or directions, the physician's orders are checked for the correct dosage schedule. When a medication order is changed and the current supply can continue to be used, the container should be flagged right away and the order change communicated to the provider pharmacy so that the next supply of the medication is labeled with the current directions. -If a medication with a current, active order cannot be located in the medication cart/drawer, other areas of the medication cart, medication room and facility are searched, if possible. If the medication cannot be located after further investigation, the pharmacy is contacted or medication removed from the emergency kit; -Medications are administered in accordance with written order of the prescriber; -If a dose seems excessive considering the resident's age and condition, or a medication order seems to be unrelated to the resident's current diagnoses or conditions, the nurse calls the provider pharmacy for clarification prior to the administration of the medication or if necessary, contacts the prescriber for clarification. The interaction with pharmacy and/or prescriber and the resulting order clarification are documented in the nursing notes and elsewhere in the medical record as appropriate; -Monitoring of side effects or medication related problems occurs continually, but particularly after medication administration and especially after the first few doses of a new medication; -The individual who administers the medication dose records the administration on the resident's 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; -If a dose of regularly scheduled medication is withheld, refused, not available, or given at a time other than the scheduled time, the space provided on the front of the MAR for that dosage is initialed and circled. An explanatory note is entered on the reverse side of the record. If a vital medication is withheld, refused, or not available the physician is notified. Nursing documents the notification and the physician's response; -If an electronic MAR system is used, specific procedures required for resident identification, identifying medications due at specific times, and documentation or administration, refusal, holding of doses, and dosing parameters such as vital signs and lab values are described in the system's user (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	manual. These procedures should be followed and may differ slightly from the procedures for using paper MARs. 1.Review of Resident #3's face sheet showed: -Originally admitted to the facility on [DATE]; -re-admitted from the hospital on [DATE]; -re-admission diagnosis of heart attack; -Existing diagnoses of diabetes mellitus, liver disease, chronic obstructive lung disease (COPD-a progressive lung condition causing airflow obstruction, leading to shortness of breath, cough, and wheezing, primarily from lung damage due to smoking or pollution), congestive heart failure, and reduced mobility. Review of the resident's significant change minimum data set (MDS, a federal mandated comprehensive assessment tool completed by facility staff), dated 12/28/25, showed: -Reentered the facility from the hospital on [DATE]; -Severe cognitive impairment; -Rejection of care (1-3 days); -Worsening change in behavior; -Used wheelchair for mobility; -Functional limitation in range of motion to bilateral upper and lower extremities; -Required substantial/maximal assistance of staff with oral hygiene and bathing; -Required partial/moderate assistance of staff with personal hygiene; -Dependent on staff for assistance with toileting, lower body dressing, and transfers; -Frequently incontinent of bowel and bladder; -Diagnoses of heart attack, anemia, congestive heart failure, high blood pressure, and diabetes mellitus; -Received pain medication; -Presence of pain, rated as an '8' on a scale of 0-10, frequent, affecting sleep, day to day activities and therapy. Review of the resident's care plan, dated 12/16/25, and revised on 01/05/26, showed: (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 - Actual harm Residents Affected - Few	-The resident is on digoxin therapy; -The resident will be free from discomfort or adverse reactions related to digoxin use; -Administer the medication as ordered by the physician; -Monitor for side effects and effectiveness every shift; -Draw labs per provider; -Increase rounding and vitals should toxicity occur; -Monitor/document/report as needed (PRN) adverse reaction of the medication: Anorexia, nausea, vomiting, diarrhea, extreme headache or visual disturbances; -Notify provider of change in condition; -Record baseline peripheral pulses; -Report to physician if pulse falls below 60 or rises above 110 or if you detect skipped beats or other changes in rhythm; -Serum digoxin levels monthly or as ordered by the physician. Review of the resident's progress note, dated 12/22/25 at 2:00 P.M., showed a nurse documented: -The resident returned from the hospital via ambulance; -The facility notified the resident's physician. Review of the resident's hospital After Visit Summary, provided by the facility, and dated 12/22/25, showed the following discharge order: -Start digoxin 125 micrograms (mcg) (0.125 milligrams (mg)) tablet, take 1 tablet by mouth daily (medication last given on December 21, 2025, at 6:01 P.M.) Review of the resident's physician order sheet showed: -A physician's order, dated 12/22/25 for digoxin 125 mcg give 1 tablet by mouth 4 times a day for heart failure. This order was discontinued the same day, 12/22/25; -This did not reflect the hospital discharge order of one time per day. Review of the resident's progress note, dated 12/22/25 at 2:21 P.M. showed the following note signed by Licensed Practical Nurse (LPN) A: -This order is outside of the recommended dose or frequency; -Digoxin tablet 125 mcg, give 1 tablet by mouth four times a day for heart failure; (continued on next page)

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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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(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 - Actual harm Residents Affected - Few	-The dosing regimen of 1 tablet 4 times per day exceeds the usual dosing regimen of 0.5 tablet every 2 days to 2 tablets daily; -The frequency of 4 times per day exceeds the usual frequency of every 2 days to daily; -The nurse did not document any follow up with the physician about the medication order. Review of the resident's December 2025 Medication Administration Record (MAR) showed: -An order, dated 12/22/25, with a start date of 12/22/25, for digoxin tablet 125 microgram (mcg) give one tablet by mouth four times per day (at midnight, 6:00 A.M., noon, and 6:00 P.M.) for heart failure; -Staff initialed administration of the medication one time on 12/22/25 at 6:00 P.M. and then the order changed. Review of the resident's progress note, dated 12/22/25 at 11:19 P.M. showed the following note signed by LPN K: -This order is outside of the recommended dose or frequency; -Digoxin tablet 125 mcg, give 1 tablet by mouth four times a day for heart failure; -The dosing regimen of 1 tablet 4 times per day exceeds the usual dosing regimen of 0.5 tablet every 2 days to 2 tablets daily; -The frequency of 4 times per day exceeds the usual frequency of every 2 days to daily; -The nurse did not document any follow up with the physician about the medication order. Review of the resident's physician order sheet showed: -A physician's order, dated 12/22/25 for digoxin 125 mcg, give 1 tablet by mouth 4 times a day for heart failure. Review of the resident's December 2025 MAR and MAR notes, showed an order, dated 12/22/25, with a start date of 12/23/25 at 10:30 P.M., for digoxin tablet 125 microgram (mcg) give one tablet by mouth four times per day (7:00 A.M., 12:30 P.M., 5:30 P.M., and 10:30 P.M.) for heart failure with the following administration entries: -On 12/23/25, at 10:30 P.M., staff documented NA (Not administered, see nurses notes), on the MAR note, staff documented waiting for pharmacy to receive orders; -On 12/24/25, at 7:00 A.M., 12:30 P.M., and at 5:30 P.M., staff documented NA. On the MAR note staff documented medication unavailable nurse notified. -On 12/24/25 at 10:30 P.M., staff left the dosage blank. -Staff did not document administration of any digoxin on 12/23/25 or 12/24/25 and did not document (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 - Actual harm Residents Affected - Few	physician notification about not administering the medication. Review of the resident's December 2025 MAR and MAR notes, showed an order, dated 12/22/25, with a start date of 12/23/25 at 10:30 P.M., for digoxin tablet 125 microgram (mcg) give one tablet by mouth four times per day (7:00 A.M., 12:30 P.M., 5:30 P.M., and 10:30 P.M.) for heart failure with the following administration entries: -On 12/25/25, at 7:00 A.M., 12:30 P.M., and at 5:30 P.M., staff initialed administration of the medication three times, and at 10:30 P.M., staff left the dosage blank; -From 12/26/25 through 12/30/25, staff initialed administration of the medication four times each day. Review of secure messaging between facility nursing staff and the resident's physician showed: -On 12/30/25 at 1:59 P.M., nursing staff messaged: Resident has slept a lot today, he/she has easily aroused. Vital signs are blood pressure = 86/52 millimeters of mercury (mm/Hg) (normal range 90-120/60-80), pulse = 62 beat per minute (normal range 60-100), respiratory rate = 22/minute (normal range 12-20). The resident has not wanted to eat today and has no energy. Resident is drinking fluids. Labs have already been collected. This nurse is concerned. Resident is a full code. Please advise; -On 12/30/25 at 3:07 P.M., the physician messaged: Were the labs ordered STAT (immediately); -On 12/30/25 at 3:22 P.M., nursing staff responded: Not the ones drawn today, the ones last week were and have been reviewed. The resident has not been very energetic since returning from the hospital this last time, but did have a heart attack; -On 12/30/25 at 4:06 P.M., the physician messaged: Can we recheck the manual BP and pulse now and recheck STAT complete blood count (CBC, a blood test that measures white and red blood cells and platelets) and comprehensive metabolic profile (CMP, a blood test that measures fluid/electrolyte balance, kidney/liver function, metabolism, and blood sugar levels). Review of the resident's December 2025 MAR showed an order, dated 12/22/25, with a start date of 12/23/25 at 10:30 P.M., for digoxin tablet 125 microgram (mcg) give one tablet by mouth four times per day (7:00 A.M., 12:30 P.M., 5:30 P.M., and 10:30 P.M.) for heart failure with the following administration entries: -On 12/31/25, at 7:00 A.M. staff initialed administration of the dose, at 12:30 P.M. and at 5:30 P.M., staff documented NA; staff did not document the reason for not administering this medication). Review of secure messaging between facility nursing staff and the resident's physician showed: -On 12/31/25 at 7:21 P.M., nursing staff messaged, unable to obtain blood return for labs, please advise; -Staff did not document any further attempt to reach the physician on 12/31/25. Review of the resident's December 2025 MAR showed an order, dated 12/22/25, with a start date of 12/23/25 at 10:30 P.M., for digoxin tablet 125 microgram (mcg) give one tablet by mouth four times per (continued on next page)

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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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(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 - Actual harm

Residents Affected - Few

day (7:00 A.M., 12:30 P.M., 5:30 P.M., and 10:30 P.M.) for heart failure with the following administration entries:

-On 12/31/25 at 10:30 P.M., staff documented NA (staff did not document reason for not administering this medication).

Review of secure messaging between facility nursing staff and the resident's physician showed:

-On 1/01/25 at 7:35 A.M., the physician responded, please push fluids and reschedule for tomorrow.

Review of the resident's January 2026 MAR showed:

-An order, dated 12/22/25, with a start date of 12/23/25 for digoxin tablet 125 microgram (mcg) give one tablet by mouth four times per day (7:00 A.M., 12:30 P.M., 5:30 P.M., and 10:30 P.M.) for heart failure;

-On 01/01/26, staff initialed administration of all four doses of digoxin;

-On 01/02/26, staff initialed administration of the 7:00 A.M. and 12:30 P.M. doses.

Review of secure messaging between facility nursing staff and the resident's physician showed:

-On 1/02/26 at 1:39 P.M., nursing staff messaged: Resident's digoxin level came back greater than 5 nanograms per milliliter (ng/ml) with a reference range of 0.9-2.0 ng/ml. The resident is currently getting 125 micrograms (mcg) four times a day. The nurse practitioner is in the facility and held the digoxin until Monday (1/05/26) with a recheck of the digoxin level on Monday. Please advise if you would like anything else done;

-On 01/02/26 at 1:50 P.M., the physician responded: Any chest pain/palpitations (racing, fluttering, or pounding heart), nausea, or vomiting? Do we have a recent CMP?

-On 1/02/26 at 2:28 P.M., the nurse messaged: Most recent CMP was on 1/01/26 and is attached. The resident has had no complaints of palpitations. The resident will not answer about chest pain. The resident is very confused and crying about the physician telling him/her to run applesauce on him/herself and talking about heel pain. The resident said he/she has had some nausea/vomiting. The resident's roommate said the resident's last meal was 4 days ago and the resident has thrown up everything since.

-On 1/02/26 at 2:32 P.M., the physician responded: Discontinue the digoxin;

Review of the resident's vital signs showed the following pulse entries for 01/02/26:

-On 01/02/2026 at 2:42 P.M., pulse = 62 beats per minute (bpm);

Review of secure messaging between facility nursing staff and the resident's physician showed:

-On 1/02/26 at 4:50 P.M., the nurse messaged: After looking into this further, it was found the resident's digoxin order from the hospital discharge was 125 mcg once every day. The admission nurse accidentally entered the order for 125 mcg four times a day. Just wanted to report this medication

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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 - Actual harm

Residents Affected - Few

error.

-On 1/02/26 at 4:51 P.M., the nurse messaged: The digoxin was discontinued as ordered today.

Review of the resident's physician order sheet showed:

-The physician's order, dated 12/22/25 for digoxin 125 mcg give 1 tablet by mouth 4 times a day for heart failure was placed on hold starting 1/02/25 and discontinued on 1/02/25.

Review of the resident's vital signs showed the following pulse entries for 01/02/26:

-On 01/02/2026 at 11:07 P.M., pulse = 68 bpm (Regular);

-On 01/02/2026 at 11:17 P.M., pulse = 86 bpm (Regular);

Review of the resident's vital signs showed the following pulse entries for 01/03/26:

-On 01/03/2026 at 7:50 A.M., pulse = 79 bpm (Regular)

-On 01/03/2026 at 7:51 A.M., pulse = 79 bpm (Regular)

-On 01/03/2026, on 11:45 A.M., pulse = 56 bpm (Regular)

Review of secure messaging between facility nursing staff and the resident's physician showed:

-On 1/03/26 at 2:45 P.M., the nurse messaged: The resident has continued to be very lethargic and confused today. Respirations =14 per minute, BP = 80/58 mm/Hg, Pulse = 62, beats per minute, but very difficult to find radial (wrist) or carotid (neck) pulses. Pulse is very thready. One nurse was able to slightly feel the radial pulse and stated it was irregular. The resident wakes to verbal stimuli but falls back to sleep pretty immediately. Heart tones very distant and difficult to hear. Please advise;

-On 1/03/26 at 3:11 P.M., the physician responded: Can we get a peripheral intravenous (IV) access and start the resident on Normal Saline (NS) IV fluids. Hold all sedating medications;

-On 1/03/26 at 4:41 P.M., the nurse responded: I put all sedating medications on hold and was able to get an IV started, I have NS running at 100 milliliters (ml) per hour;

-On 01/03/26 at 4:53 P.M., the physician responded: Administer a bolus of 500 ml, then continue 100 ml per hour;

-On 01/03/26 at 4:54 P.M., nurse responded: Doing that now.

Review of the resident's vital signs showed the following pulse entries for 01/03/26:

-On 01/03/2026 at 10:14 P.M., pulse = 60 bpm.

Review of the resident's vital signs showed staff documented the following pulse entries for 01/04/26:

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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	

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 0760

Level of Harm - Actual harm

Residents Affected - Few

-On 01/04/2026 at 12:25 A.M., pulse = 56 bpm (Irregular – unable to determine (UTD) onset);

-On 01/04/2026 at 6:22 A.M., pulse = 58 bpm (Irregular – UTD onset);

-On 01/04/2026 at 8:45 A.M, pulse = 49 bpm;

-On 01/04/2026 at 9:13 A.M. pulse = 49 bpm (Regular);

-On 01/04/2026 at 9:14 A.M., pulse = 49 bpm (Regular).

Review of secure messaging between facility nursing staff and the resident's physician showed:

-On 1/04/25 at 11:39 A.M., a nurse messaged: The resident's IV went bad. The resident has poor veins. May we have an order for a peripherally inserted central catheter (PICC, an IV that runs from the arm to a large vein near the heart) or midline (an IV that runs from the arm to an arm pit area large vein for IV fluids) please;

-On 1/04/25 at 11:45 A.M., the nurse added: Or may we discontinue the IV fluids;

-On 1/04/26 at 12:01 P.M., the physician messaged: Condition update and assessment please;

-On 1/04/26 at 1:12 P.M., the nurse responded: Resident is still lethargic but easily aroused. Weak pulse, rate = 49/beats per minute and blood pressure =101/48 mm/Hg;

Review of the resident's vital signs showed the following pulse entries for 01/04/26:

-On 01/04/2026 at 1:49 P.M., pulse = 51 bpm (Regular).

Review of secure messaging between facility nursing staff and the resident's physician showed:

-On 1/04/26 at 4:47 P.M., the physician responded: Holding Metoprolol for blood pressure less than 100/60 and pulse less than 60?

-On 1/04/26 at 4:48 P.M., the physician asked: What is the resident's blood sugar;

-On 1/04/26 at 4:53 P.M., the physician messaged: No PICC or midline-push oral fluids;

-On 1/04/26 at 5:13 P.M., the nurse messaged: Update, the family was informed of the resident's condition and requesting the resident be sent to the hospital. Will send to hospital;

-On 1/04/26 at 5:13 P.M., the physician responded: Noted.

Review of the resident's hospital physician progress note, dated 1/05/26, showed:

-Resident admitted to the hospital on [DATE] with altered mental status. Family reports resident was in a nursing home and was given too much digoxin over the last few days and was given IV fluids to counteract. Upon arrival to the emergency room resident was found to be hypotensive (low blood pressure);

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	265477	A. Building B. Wing	01/13/2026

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 0760 Level of Harm - Actual harm Residents Affected - Few	-Digoxin toxicity, digoxin level = 6.6 ng/mL); -Resident was given Digibind (an antidote used to treat life-threatening overdose or toxicity from digoxin) and Levophed (norepinephrine, a potent medication administered IV to treat dangerously low blood pressure that does not improve with fluid replacement); -Resident is now admitted to the intensive care unit (ICU) for further evaluation and management; -Overnight no acute events resident continues on multiple doses of vasopressors (medications to raise blood pressure). During an interview on 1/06/26 at 11:57 A.M., the NP said the following: -On Friday, 1/02/26, one of the nurses notified him/her that the resident's digoxin level was greater than 5 ng/ml; -He/she checked the resident's digoxin order and said he/she had never seen that much digoxin given to a resident; -He/she placed the medication on hold, told the nurse to send a message to the resident's physician, and monitor the resident's vital signs; -The NP assessed the resident, and he/she appeared baseline, the resident had some memory issues, but not a new issue; -On 1/03/26, he/she asked the nurse to start the resident on IV fluids because the resident's blood pressure was 80/58 mm/Hg; -Nurses should notify the physician or NP if the resident's blood pressure or pulse is low. During an interview on 1/06/26 at 1:00 P.M., LPN A said the following: -When Resident #3 returned from the hospital on [DATE], he/she reviewed the resident's hospital discharge orders and reviewed the medications; -He/she then placed an order for digoxin into the resident's electronic health record as a physician order; -He/she did not realize the order he/she entered for digoxin did not match the hospital discharge order; -He/she did not notify the physician of the resident's return, but assumed the physician would review the resident's medication orders; -He/she assumed management notified the resident's physician when a resident returned from the hospital; -When a nurse entered an order that was outside of the recommended dosage, a warning message generally popped up and the nurse had to click on the message to confirm after reading the message and (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 - Actual harm Residents Affected - Few	then the message would become a progress note; -When he/she entered the digoxin order, he/she did not see the warning message pop up about the dosage; -After his/her error entering the incorrect digoxin order, the director of nursing spoke with the nurse about the correct process for entering orders. During an interview on 1/7/26 at 9:40 A.M., the Director of Rehabilitation (DOR) said the following: -On Wednesday, 12/31/26, the resident said he/she had vomited and complained of nausea. The DOR saw an emesis basin at the resident's bedside. Since the resident was not feeling well, therapy did not work with the resident; -On Thursday, 1/01/26, and on Friday, 1/02/26, he/she noticed a change in the resident; -The resident showed very little participation in therapy; -He/she was not eating or drinking much, despite encouragement from staff; -On 1/02/26, the resident was sleepy; -The DOR looked at the resident's medical record and saw the resident had a critically high digoxin level, he/she went and informed the nurse, Registered Nurse (RN) E, who was previously unaware of the lab result. The nurse then reported the lab result to the nurse practitioner. During a phone interview on 1/07/26 at 3:34 P.M., the facility physician said the following: -The facility notified him/her that the resident's digoxin level was greater than 5 ng/ml; -The resident was non-compliant with taking medication and was difficult to manage; -The physician said nursing informed him the resident did not initially want to go to the hospital when the high digoxin level was discovered, and the resident was his/her own responsible party; -The physician said to prevent medication errors, the facility should have checks and balances in place and the pharmacy should have caught the medication error and should not have filled the unusually high dose of digoxin without checking with the facility/physician; -The physician said the pharmacy should catch medication errors; -The physician said he believed he saw the resident, but did not notice the digoxin order. During an interview on 1/07/26 at 1:05 P.M., Certified Medication Technician (CMT) F said the following: -Digoxin should be given one time per day. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	During an interview on 1/07/26 at 1:24 P.M., the Assistant Director of Nursing (ADON) said the following:-On Friday, 1/02/26, staff realized Resident #3's digoxin was critically high and discovered the resident was on the wrong dose of the medication; -Some signs of digoxin toxicity included low vital signs, which the nurse found when reviewing the resident's medical record after the resident went to the hospital; -He/she was not aware of any condition changes with the resident, except the resident was not super engaged during therapy, but that was not unusual for the resident; -He/she was unsure if the nurses communicate admission/re-admission order to the facility physician; -He/she was unsure if nurses did any type of second check on physician orders to ensure accuracy. 2. Review of Resident #4's face sheet showed: -Originally admitted to the facility on [DATE], readmitted on [DATE] from the hospital; -Diagnoses of paraplegia (impairment in motor or sensory function of the legs), lumbar spina bifida (a condition occurring during embryonic development when the spine/spinal cord does not form properly), and history of thrombosis (a stationary blood clot) and embolism (a traveling blood clot that gets stuck causing a blockage). Review of the resident's quarterly MDS, dated [DATE], showed: -Cognitively intact; -Functional limitation in range of motion to bilateral lower extremities; -Presence of a urinary catheter; -Frequently incontinent of bowel; -Required partial/moderate staff assistance with toileting, hygiene and showers; -Required set-up/clean up assistance with eating and oral hygiene; -Diagnoses of spina bifida and paraplegia; -Resident is on anticoagulants. Review of the resident's care plan, revised on 11/11/25, showed the following: -Anticoagulant medication use: At risk for abnormal bleeding, hemorrhage and/or increased/easy bruising related to anticoagulant medication use; -Deep vein thrombosis prophylaxis (prevention); (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 - Actual harm Residents Affected - Few	-Goal will be free from signs and symptoms of abnormal bleeding; -Lab values will be maintained within therapeutic range. As determined by their physician; -Administer anticoagulant as currently prescribed by the resident's physician (see current physician orders); -Observe and report any of the following signs and symptoms of bleeding: Bleeding gums, nose bleeds, unusual bruising, black stools, pink or discolored urine; -Report to nursing any unusual bleeding or bruising; -Schedule lab tests as ordered by the physician to monitor coagulation factors. Report results to the physician. Review of the resident's hospital Discharge summary, dated [DATE], showed the following order: -Warfarin (coumadin), 1 milligram (mg) tablet, staff to administer 3 tablets on Mondays, and 2 tablets all other days, by mouth daily; -Hold today, physician to recheck prothrombin time (PT, a test measuring how long it takes for blood to clot)/International Normalized Ratio (INR, a standardized measurement used in a PT blood test to monitor how long it takes for blood to clot, crucial for people taking blood thinning medication like warfarin to ensure they are within safe range (typically 2-3) to prevent excessive bleeding or clotting) on 12/24/25. Review of the resident's physician order sheet showed the following orders: -Warfarin sodium oral tablet 1 mg, give 3 tablets (total 3 mg) by mouth one time a day related to complete paraplegia, order dated 12/23/25, with a start dated of 12/24/25; -This order did not match the hospital discharge order of 3 mg on Mondays and 2 mg all other days. Review of the resident's December 2025 MAR showed the following order: -Warfarin sodium oral tablet 1 mg, take 3 tablets by mouth one time a day at 9:00 A.M. related to paraplegia, start date 12/24/25. -Staff initialed administration of the medication daily from 12/24/25-12/31/25. Review of the resident's December 2025 Nurse MAR showed the following order: -Monitor for anticoagulant side effects two times a day on 7:00 A.M.-3:00 P.M. shift and on 11:00 P.M.-7:00 A.M. shift; -Staff initialed monitoring of side effects one time on 12/23/25 during the 11:00 P.M.-7:00 A.M. shift and two times a day from 12/24/25-12/31/25. Review of the resident's physician order sheet showed the following orders

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to document a change in condition and discharge to the hospital in one resident's (Resident #8) progress notes. The facility census was 106.1. Review of Resident #8's face sheet showed the following:-The resident admitted on [DATE];-The resident was his/her own responsible party;-Diagnoses included chronic obstructive pulmonary disease (COPD-a progressive lung condition causing airflow obstruction, leading to shortness of breath, cough (often with mucus), and wheezing, primarily from lung damage due to smoking or pollution), bipolar disorder (a serious mental illness causing extreme shifts in mood, energy, and activity), extrapyramidal and movement disorder (EPS-involuntary movement disorders, often caused by medications like antipsychotics), anxiety and insomnia. Review of the resident's quarterly MDS, dated [DATE], showed the following:-The resident was cognitively intact;-The resident required supervision or touching assistance for all activities of daily living. Review of the resident's discharge return anticipated MDS, dated [DATE], showed the following:-The resident did not require assistance for eating, oral hygiene, toilet hygiene, upper body dressing and personal hygiene;-The resident required supervision or touching assistance to shower, lower body dressing and putting on and taking off footwear;-Diagnoses included diabetes mellitus, malnutrition, anxiety disorder and bipolar disorder;-The resident received scheduled and as needed pain medications;-The resident had shortness of breath;-The resident received antipsychotic, antianxiety and antidepressant medications. Review of the resident's care plan, revised 12/15/25, showed the following:-The resident had episodes of hypoglycemia (low blood sugar);-Monitor, document and report as needed signs and symptoms of hypoglycemia such as sweating, tremor, increased heart rate, pallor, nervousness, confusion, slurred speech, lack of coordination and staggering gait;-Monitor, document and report as needed any signs or symptoms of hyperglycemia: increased thirst and appetite, frequent urination, weight loss, fatigue, dry skin, poor wound healing, muscle cramps, abdominal pain, Kussmaul breathing (deep, rapid, labored and consistent breating pattern that signals severe metabolic acidosis, most commonly diabetic ketoacidosis (DKA-a severe, life-threatening condition where the body cannot use sugar for fuel, breaking down fat instead, which produces acid ketones)), acetone breath (smells fruity), stupor or coma;-Monitor, document and report as needed any signs or symptoms of infection to open areas such as redness, pain, heat, swelling or pus formation;-The resident used antipsychotic medications related to bipolar disorder;-Monitor and record occurrence of target behavior symptoms such as pacing, wandering, disrobing, inappropriate response to verbal communication, violence or aggression towards staff or others and document per facility protocol;-The resident used antidepressant medication related to depression;-Monitor, document and report as needed adverse reactions to antidepressant therapy such as change in behavior, mood or cognition, hallucinations or delusions, social isolation, suicidal thoughts, withdrawal, decline in activity of daily living ability, continence, no voiding, constipation, fecal impaction, diarrhea, gait changes, rigid muscles, balance problems, movement problems, tremors, muscle [NAME], falls, dizziness, vertigo, fatigue, insomnia, appetite loss, weight loss, nausea and vomiting, dry mouth or dry eyes;-The resident used antianxiety medications related to anxiety disorder;-Monitor and record occurrence of behavior symptoms such as pacing, wandering, disrobing, inappropriate response to verbal communication, violence or aggression towards staff or others and document per facility protocol. Review of the resident's census showed the resident had hospital leave on 12/27/25. Review of the resident's nurse's progress notes showed no documentation of a change in condition or notification of physician for need to send the resident to the hospital on [DATE]. 2. During (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	an interview on 01/07/26, at 1:24 P.M., the ADON said the following:-If a resident was sent to the hospital, the charge nurse should document a nurse's note in the chart that contained the residents symptoms, concerns, vitals and notifications of the physician and responsible party. 3. During an interview on 01/12/26, at 12:00 P.M., RN J said if a resident was sent to the hospital the charge nurse documented in a nurse's progress note. 4. During an interview on 01/12/26, at 12:57 P.M., LPN C said the following:-If a resident needed to go to the hospital, he/she called EMS, printed a medication list and filled out a transfer form;-He/she documented in a nurse's progress note or change in condition transfer form the residents symptoms that required hospitalization and notification of the physician and resident's responsible party or next of kin. 5. During an interview on 01/13/26, at 3:16 P.M., the Administrator said the following:-When residents went out to the hospital, nurses documented the residents change in condition and notification of the resident's physician and responsible party.