

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  01/27/2026
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)		
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>Based on interview and record review, the facility failed to ensure notifications were made to resident responsible parties and physicians of all resident refusal of a scheduled medical appointments when staff failed to document notification of the one resident's (Resident #1) responsible party and physician when the resident refused to attend a scheduled medical appointment related to the removal of an inserted ureteral stent (thin, flexible tube placed in ureter to keep the passageway open for urine to flow from the kidney to the bladder). The facility census was 105. Review of the facility's policy titled Notification of a Change in Condition, revised 01/20/26, showed the following:-The attending physician/physician extender (nurse practitioner (NP), physician assistant (PA), or clinical nurse specialist (CNS)) and the resident representative will be notified of a change in a resident's condition, according to standards of practice and federal and/or state regulations;-Guideline for notification of physician/resident representative (not all inclusive) include significant change in medical or cognitive baseline and refusal to take prescribed medications;-Document in the interdisciplinary team notes physician/physician extender notification and notification of resident representative. 1. Review of Resident #1's face sheet (admission data) showed the following: -readmission date of 05/14/25;-Resident had a guardian (legal document allowing someone to make decisions on your behalf) listed with name and phone number;-Diagnoses included hydronephrosis (swelling of one or both kidneys due to a buildup of urine) with ureteropelvic junction obstruction (blockage where the renal pelvis connects to the ureter (carries urine from the kidney to the bladder)) and cognitive communication deficit.Review of the resident's annual Minimum Data Set (MDS - a federally mandated comprehensive assessment completed by facility staff), dated 01/14/26, showed the resident had severely impaired cognitive skills. Review of the resident's care plan, revised 01/16/26, showed the following:-The resident had impaired cognitive function/dementia or impaired thought processes related to vascular dementia and history of traumatic brain injury;-Communicate with the resident's responsible party regarding his/her capabilities and needs;-Monitor/document/report to the physician of any changes in cognitive function, specifically changes in decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, and level of consciousness and mental status;-The resident had acute renal failure related to kidney disease. Review of the resident's progress note dated 01/19/26, at 7:16 A.M., showed Licensed Practical Nurse (LPN) D documented the following: -Staff notified the on-call provider at 6:44 A.M. after he/she was called to the resident's room because a certified nurse aide (CNA) stated the resident did not act right;-Call placed to the on-call provider who agreed that the resident needed to be sent out;-Staff called emergency medical services (EMS) who picked up the resident at 7:07 A.M.Review of the resident's Emergency Department to Admission hospital paperwork, dated 01/19/26, showed the resident had a history of urinary tract infections (UTIs) and had complicated UTI requiring stent. The resident underwent lithotripsy (uses shockwaves to break stones into small</p> <p>(continued on next page)</p>		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:  265477	Facility ID:  265477  If continuation sheet Page 1 of 4

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F 0580  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	said he was not sure if the facility notified him of the resident refusing the 11/07/25 appointment. During an interview on 01/27/26, at 4:12 P.M., the administrator said she expected staff to document in the progress notes if a resident refused an appointment and staff should notify the resident's guardian and provider. #2723198		