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	06/12/2026

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. Based on observation, interview, and record review, the facility failed promote each resident's right to self-determination when staff failed to honor one resident's (Resident #70) reason shower preference for two showers a week. The facility census was 113.Review showed the facility did not provide a shower policy that addressed frequency of showers. 1. Review of Resident #70's face sheet (brief resident profile sheet) showed the following:-admission date of 02/23/26;-Diagnoses included chronic obstructive pulmonary disease (COPD - lung disease), type two diabetes mellitus (DM - metabolic disease), amputation of right leg above knee, cellulitis (deep inflammation of the tissues just under the skin, caused by infection) of left lower limb, depression, and generalized muscle weakness. Review of the resident's care plan, reviewed/revised on 03/24/26, showed the following:-Required one staff assist with showers; -Dependent on staff for personal hygiene and oral care;-Staff should monitor participation and adjust activity offerings according to the resident's preference and energy level. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff), dated 05/20/26, showed the following:-Cognitively intact;-Used manual wheelchair;-Dependent on staff for toileting hygiene;-Maximal assistance needed for showering;-Dependent on staff assistance for personal hygiene. Review of the resident's Skin Monitoring: Comprehensive Certified Nursing Assistant (CNA) Shower Review, showed staff provided showers to the resident on the following dates:-On 04/10/26;-On 04/16/26 (six days later);-On 04/22/26 (six days later);-On 04/27/26 (five days later);-On 05/02/26 (five days later);-On 05/09/26 (seven days later);-On 05/12/26;-On 05/20/26 (eight days later.).-On 05/25/26 (five days later) -On 06/01/26 (seven days later). During an interview on 06/09/26, at 10:39 A.M., the resident said the following:-He/she received one shower a week. The resident would like to have at least two showers a week;-He/she last received a shower seven days ago;-He/she said I just feel yucky.;-The resident has discussed two or three times with the Administrator about not receiving at least two showers per week. During an interview on 06/12/26, at 11:16 A.M., CNA K shower aide said the following:-Every resident should have a designated shower day. Sometimes the resident's shower schedule changes due to appointments or activities;-CNAs assigned to work the hall providing overall direct care on the hall do not give showers;-CNA K was assigned to give the resident his/her showers. He/she has not been able to give the resident a shower twice a week because he/she was too busy;-Therapy gave the resident a shower last week;-He/she attempted to give the resident a shower on Monday, but the resident had an outside appointment all day; -The resident was the next shower on the schedule. During an interview on 06/12/26, at 1:45 P.M., CNA P said the following:-He/she did not have time to give residents a shower during the shift;-He/she did not give residents a shower while working the general floor as a CNA;-Only shower aides give residents showers. During an interview on 06/12/26, at 12:16 P.M., Assistant Director of Nursing (ADON) B said the following:-He/she expected residents to receive showers at least twice a week and be given a choice;-If a shower aide was not available, an aide should give the resident a shower. During an interview on 06/12/26, at 4:35 P.M., the Director of Nursing (DON) said the following:-He/she expected all residents to receive at least two showers per week and have a choice;-He/she did not know the resident was not getting his/her preference of (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at least two showers per week. During an interview on 06/12/26, at 3:15 P.M., the Administrator said the following:-There was no shower policy regarding frequency. Showers were given according to resident choice; -The resident had not discussed his/her shower preference of at least twice per week with the Administrator. Complaint #2980701 and #3041981

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a clean, comfortable and homelike environment for all resident including (Resident #65, #111, #87, #8, #31, #38, and #82) when the facility failed to eliminate strong urine odors, failed to clean floors in a timely fashion, failed to keep walls clean, failed to repair a faucet timely and failed to remove trash timely. The facility census was 113. Review of a facility policy entitled Basic Cleaning Concepts, undated, showed the following:-General sanitizing: To make a surface or area clean by removing dirt, germs or unwanted substances;-Cleaning: The physical removal of dust, soil, blood and body fluids. Cleaning physically removes germs. It is accomplished with water, detergents and mechanical action;-Surfaces must be cleaned first before applying disinfectant in order to kill germs;-Hospital clean is a measure of cleanliness routinely maintained in care areas of the health care setting; floors are free of stains, visible dust, spills, and streaks. 1. Observations showed the following:-On 06/07/26, at 2:50 P.M., a strong urine odor permeated the entry area to the facility; -On 06/07/26, at 6:46 P.M., the facility entrance lobby smelled strongly of urine; -On 06/08/26, at 8:30 A.M., a strong urine odor present at the front door area of the facility.-On 06/09/26, at 6:00 A.M., a strong urine odor present in the front lobby of the facility. Observation on 06/09/26, at 12:37 P.M., showed a strong urine odor outside of the conference room and into the 100 and 200 hallways. Observation on 06/11/26, at 2:56 P.M., showed Resident #65 and Resident #111 in the common area talking. Resident #65 said, this couch smells like piss to Resident #111 and who nodded in agreement. During an interview on 06/12/26, at 4:18 P.M., Certified Nursing Assistant (CNA) S said the following: -There should not be a strong urine odor throughout the facility; -The aide acknowledged there was a strong urine odor. During an interview on 06/12/26, at 5:02 P.M., the Director of Nursing (DON) said they try to keep the facility clean and odor free, but it is tough because of a resident in the 500 hallway that urinates in the room and trash. During an interview on 06/12/26, at 5:14 P.M., the Administrator said they try to keep the facility clean and without strong foul odors, but a resident in the 500 hall throws urine and did not like to be changed. 2. Observation on 06/07/26 showed the following:-At 3:01 P.M., a trail of a yellow, liquid substance was on the entire length of floor from room [ROOM NUMBER] to room [ROOM NUMBER] on the 200 hallway; -At 3:14 P.M., the trail of a yellow, liquid substance remained on the entire length of floor from room [ROOM NUMBER] to room [ROOM NUMBER] on the 200 hallway. -At 3:20 P.M., the trail of a yellow, liquid substance remained on the floor in the 200 hallway.-At 3:48 P.M., the yellow, liquid substance remained on the 200 hallway floor. An aide pushed a resident in a wheelchair down the 200 hallway. Staff did not clean the floor;-At 4:12 P.M., the yellow, liquid substance remained on the hallway floor. Resident #87 walked on the hall floor bare foot near and around the area of the yellow liquid substance;-At 4:29 P.M., another aide pushed a different resident in a wheelchair down the 200 hallway. The yellow, liquid substance was smeared and partly dried up. 3. Review of Resident #8's face sheet showed the following:-admission date of 09/11/18;-Diagnoses included Parkinson's disease (progressive disorder of the central nervous system that affects movement and worsens over time), severely overweight, depression, bipolar disorder (extreme mood swings), dementia, chronic fatigue, overactive bladder, and urinary incontinence. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff), dated 06/03/26, showed the following:-Cognition intact;-Frequently incontinent of bladder;-Functional limitation to range of motion: upper and lower extremities, both sides;-Manual wheelchair, propelled by self;-Required partial/moderate assist with toileting. Review of the resident's care plan, current as of 06/12/26, showed the resident had frequent bladder incontinence and needed assistance with toileting; resistant to care, but encourage to ask for assistance. Observation and interview on 06/08/26, at 2:35 P.M., showed the following:-A puddle of liquid on the (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	floor of 300 hall outside the doorway of Resident #8;-Resident #31 exited his/her room and walked down the hall. He/she pointed at the puddle, made a face, pointed at the room and the puddle, and said that Resident #8 had urinated onto the floor again and that Resident #8 had urine odor all the time;-Resident #31 continued down the hall and told a staff member about the puddle. The staff member looked down the hall toward the puddle and nodded his/her head at Resident #31. Observation on 06/08/26, at 2:44 P.M., showed the puddle remained outside Resident #8's doorway. Two housekeeping staff walked down the hall toward the puddle but turned onto the 400 hall (two doors away) before reaching Resident #8's room. Observation on 06/08/26, at 2:45 P.M., showed Resident #8 sitting on his/her bed removing his/her wet pants and underwear. The puddle remained on the floor outside his/her room. Four staff conversed in the hallway two doorways away from Resident #8's room. The two housekeeping staff returned from the 400 hall but turned in the opposite direction from the puddle. Observation on 06/08/26, at 2:50 P.M., showed Resident #8 put on dry clothing and sat down in his/her wheelchair. Observation on 06/08/26, at 2:54 P.M., showed Resident #38 exited his/her room. As he/she walked past the puddle in front of Resident #8's room, Resident #38 waved a hand in front of his/her face, pointed at the floor, and said, They need to change (him/her)! That's urine! Observation on 06/08/26, at 2:55 P.M., showed an unknown therapy staff walked to the end of 300 hall, turned around and walked back up the hall the way he/she came, stepping around the puddle. Observation on 06/08/26, at 3:01 P.M., showed the Corporate Nurse Consultant walked down to the end of the 300 hall and looked down at the floor and puddle. The nurse turned and walked back up the hall. Resident #8 approached the puddle in his/her wheelchair from inside his/her room and placed a towel on top of the puddle. The nurse returned at 3:03 P.M. with supplies to clean up the puddle. 4. Observation on 06/10/26, at 8:47 A.M., showed the following:-Resident #82 spilled a cup of soda on the floor around the bed;-CNA Q answered the call light, used a towel to wipe off the soda and placed the resident's dirty cup on top of the roommate's bedside table;-CNA Q did not pick up the wet receipt, straw wrappers, used tissues, empty plastic bag, or food crumbs off the floor. 5. Observation and interview on 06/09/26, at 10:14 A.M., showed Resident #50 pointed out two areas on the floor near the door with a dried orange substance the resident called food. The resident said the substance had been there for days. 6. During an interview on 06/12/26, at 9:35 A.M., the Activity Assistant said the following:-If there was a spill, he/she will lay something over it and then let a housekeeper (HK) know;-If it is urine, then he/she will inform a CNA or nurse;-If it is juice or water, then he/she will let HK know and they do try to find a caution, wet sign. During an interview on 06/12/26, at 4:18 P.M., CNA S said all staff should clean up a spill and put up a wet floor sign. During an interview on 06/12/26, at 3: 54 P.M., CNA R said the following:-Staff should clean up a spill immediately with a towel or something and put up a wet floor sign. Aides do not usually mop. Housekeeping mops. During an interview on 06/12/26 at 1:55 P.M., Certified Medication Technician (CMT) P said the following:-If there is a spill, get a towel and put it over the spill;-If it is not identifiable, then a CNA or he/she or a nurse would clean it up;-If it is not any kind of bodily fluid, then HK is able to clean it. During an interview on 06/12/26, at 1:40 P.M., the Assistant Director of Nursing (ADON) A said the following:-If someone comes across a spill, they should notify a nurse or CNA to clean it up;-HK is only allowed to clean up non-bodily fluid spills;-If it is some kind of bodily fluid, they should notify nursing;-Whoever finds a spill should first put up a wet floor sign for safety. During an interview on 06/12/26, at 4:09 P.M., ADON B (also a charge nurse) said if there was a spill on the floor, staff should place a wet floor sign, clean up immediately, and inform housekeeping. During an interview on 06/12/26, at 2:20 P.M., the Administrator said the following:-Spills need to be addressed as soon as noticed;-The HK department is not allowed to clean up bodily fluids and this is how it is preferred;-If something is from a resident, perhaps they become ill and it got on the floor or a surface, nursing is expected to address that;-If it is a drink or food, HK would take care of those cleaning tasks. 7. During an observation and interview on 06/07/26, at 3:25 P.M., Resident #82 said the following:-The shared shower room faucet was broken. There was hot (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	water continuously running, and the water temperature could not be adjusted;-The shower had mildew on the tiles, grout, and ceiling;-There were no paper towels in the resident's bathroom;-He/she had reported these issues to staff multiple times. Observation on 06/08/26, at 10:23 A.M., showed the following in the shower room in between the 300 and 400 hallways: -Shower head running water at a low, steady pressure;-Unable to shut off the water in the shower. The faucet was broken. Water continously ran; -A thin line of mildew in the corner tiles, all along the bottom where the wall meets the floor, and areas on the ceiling of the shower;-Fan air vents did not work. The fans did not turn on. During an interview on 06/12/26, at 1:50 P.M., CNA M said he/she had worked at the facility for the last nine months and the shower head faucet had been broken and would not turn off the entire time. 8. Observation on 06/08/26, at 10:23 A.M., showed in the shower room in between the 300 and 400 hallways, the trash can was full of dirty briefs and wipes. The trash can did not have a liner in it. 9. During an interview on 06/11/26, at 2:46 P.M., CNA C said the following:-Trash cans should have a liner inside and trash should be taken out of a resident's room before exiting;-All staff should clean noticibly dirty surfaces. During an interview on 06/11/26, at 2:50 P.M., CNA M said the following:-All staff should clean dirty surfaces as needed;-Trash cans should have a liner inside and trash should be taken out when leaving a room. During an interview on 06/12/26, at 4:18 P.M., CNA S said the following: -Staff should take out the trash at the end of the shift and after incontinence care; -Housekeeping should do the daily room cleaning. During an interview on 06/12/26, at 3:54 P.M., CNA R said the following:-Staff should take out the trash at the end of the shift or after a resident was changed;-Trash cans should have liners in them;-All staff should clean a bedside table if he/she noticed it was dirty. During an observation and interview on 06/12/26, at 4:09 P.M., ADON B said the following:-Housekeeping completes the daily cleaning;-He/she expected the aides to take out the trash after incontinence care and to place a liner in the trash can;-He/she expected aides to pick trash up off the floor and to clean dirty bedside tables. During an interview on 06/12/26, at 4:35 P.M., the DON said the following:-He/she expected aides to take out the trash when full or after incontinence care and replace with a new liner; -He/she expected any staff member to clean a spill or dirty area; -Housekeeping and laundry are a combined department. Housekeeping does the deep cleaning; sweep, mop, dust, but do not clean up body fluids. Only aides and nurses can clean up body fluids; -All staff have access to cleaning supplies. There are no housekeepers on the night shift;-He/she expected shower rooms to be cleaned by shower aides in between residents and housekeeping to do the deep cleaning of the shower room at end of the day;-Housekeepers work eight hour shifts. Two shifts per day during the day and evening;-The housekeeping supervisor conducts cleaning follow-ups. Complaint #2980701, #3009095, #3035805, and #3037972

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain staff in sufficient numbers with sufficient training to ensure call lights were answered in a timely manner for seven residents (Residents #10, #70, #82, #86, #94, #65, and #61). The facility census was 113.Review of the facility policy Resident Call System, revised 06/02/26, showed the following:-The facility call system relays calls directly to a centralized work area from the resident's bedside, toilet, and bathing areas;-The call system was accessible to residents as required by State/Federal guidelines;-Upon admission, nursing will orientate residents on how to utilize the resident call system;-During rounds, nursing and Interdisciplinary Team (IDT) members will ensure resident call system is within reach of the resident;-Any malfunction, outage, or interruption of the resident call system will be addressed immediately;-Interim measures may include handheld manual bells, increased safety rounds, one-to-one observation, or other measures necessary to ensure resident access to assistance until repairs were completed;-Maintenance Director will complete routine resident call system inspections. 1. Review of Resident #10's face sheet (gives basic profile information) showed the following:-admission date of 10/29/25;-Diagnoses included breathing disorder, diabetes, schizophrenia (a mental health condition that affects how people think, feel and behave), depressive disorder, difficulty in walking, repeated falls, muscle weakness, need for assistance with personal care, and pain. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff), dated 04/23/26, showed the following:-Moderately impaired cognition;-Required supervision or touch assistance for toileting hygiene, personal hygiene, bathing, dressing, mobility, and walking with the use of a walker. Review of the resident's care plan, current as of 06/12/26, showed the following:-Activities of daily living (ADL) performance deficit;-Encourage use of call bell for assistance;-At risk for and history of falls;-Resident to ask for assistance with ambulating long distances with his/her walker. Observation and interview on 06/08/26, at 2:25 P.M., showed the following:-The resident said he/she needed some assistance with personal care, showering, and sometimes with mobility using his/her walker or a wheelchair;-The resident said he/she used the call bell to request assistance or to ask for pain medication or to tell the nurse if he/she didn't feel well or had another problem;- He/she said sometimes the staff took forever to answer the call bell and sometimes just ignore it;-As a demonstration, the resident activated his/her call bell. The call light outside his/her door lit up. Observation on 06/08/26, at 2:44 P.M., showed the resident's call light remained on. Two housekeeping staff walked from the cleaning supply room through the front half of 300 hall, did not enter the resident's room, and turned onto the 400 hall. Observation on 06/08/26, at 2:45 P.M., showed two housekeeping staff, one certified nursing assistant (CNA), and one additional staff conversed at the front end of 300 hall. Staff did not respond to the resident's call light. Observation on 06/08/26, at 2:50 P.M., showed the resident's call light remained on. No staff had entered the room. Observation on 06/08/26, at 2:55 P.M., showed a therapy staff walked to the end of the resident's hall but did not enter the resident's room. Observation on 06/08/26, at 2:58 P.M., showed a resident knocked on both 300/400 hall shower room doors, received no response, waved his/her arms around, and said, Why can't I ever find a CNA? Observation on 06/08/26, at 3:01 P.M., showed the resident's call light remained on. Observation on 06/08/26, at 3:05 P.M., showed the resident's call light remained on. The Activities Director pointed out the call light equipment in the nurses' office. She said the staff could hear the call lights ring but wasn't sure if the room number could be noted in the office and could not show a room number indicator. Observation on 06/08/26, at 3:13 P.M., showed the resident's call light remained on. No staff had entered the resident's room. Observation on 06/08/26, at 3:15 P.M., showed two certified medication technicians (CMT) stood at a medication cart in the hallway. The resident's call light remained on and visible from (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the cart. Observation on 06/08/26, at 3:19 P.M., showed the resident's call light remained on. The resident said nobody had answered his/her call light since he/she turned it on. Observation on 06/08/26, at 3:33 P.M., showed the resident's call light remained on (one hour and eight minutes since being turned on). The resident ambulated from his/her room and proceeded up the 300 hall toward the front of the building. He/she said that nobody had responded to his/her call light, but he/she was tired of waiting and wanted to go to the dining room to sit. 2. Review of Resident #70's face sheet showed the following:-admission date of 02/23/26;-Diagnoses included chronic obstructive pulmonary disease (COPD - lung disease), type two diabetes mellitus (DM - metabolic disease), amputation of right leg above knee; cellulitis (deep inflammation of the tissues just under the skin, caused by infection) of left lower limb, depression, and generalized muscle weakness. Review of the resident's care plan, last reviewed/revised on 03/24/26, showed the following:-Dependent on staff for personal hygiene and oral care;-The resident had bowel incontinence and mixed bladder incontinence related to immobility;-Staff should check the resident every two hours and assist with toileting as needed;-Staff should clean the resident's perineal area with each incontinence episode. Review of the resident's quarterly MDS, dated [DATE], showed the following:-Cognitively intact;-Used manual wheelchair;-Dependent on staff for toileting hygiene;-Dependent on staff assistance for personal hygiene. During an interview on 06/09/26, at 10:39 A.M., the resident said the following:-He/she lived in the facility since March 2026;-The call light in his/her room was broken for two months. Recently, staff fixed the call light;-Aides answer the call lights, come into the room, clear the light, say they will be back in soon, but do not come back;-He/she has waited two to six hours in urine and poop filled brief;-Last week, the resident had to propel him/herself to the nurses' station in the wheelchair to tell staff his/her brief needed to be changed. His/her brief was so wet that urine leaked onto the floor down the entire hallway. He/she was humiliated. 3. During an interview on 06/07/26, at 3:25 P.M., Resident #82 said the following:-He/she depended on staff for bathing, incontinence care, and used a Hoyer lift (mechanical lift for non-weight bearing residents) for transfers;-Aides did not answer call lights timely;-One day last week, he/she waited in his/her own urine and feces for three hours for brief to be changed;-He/she must regularly call the main facility phone number to tell a nurse that his/her call light was on and needed help;-Call lights take longer to be answered on night shift. 4. During an observation and interview on 06/08/26, at 11:22 A.M., Resident #86 said the following:-The resident said he/she needed one staff assistance for care, used a manual wheelchair, and propelled the wheelchair with his/her feet;-Call lights can take up to eight hours to be answered;-Often, staff come into the room to answer the call light, clear the call light, and tell him/her staff will be back in a minute and never come back;-The resident pushed his/her call light and the light on the outside of room door was faint and flickered. 5. During an interview on 06/08/26, at 11:43 A.M., Resident #94 said the following:-A call light could take a couple of hours to be answered;-A few weeks ago, the resident's roommate fell so he/she pushed the call light to get help and no one came to answer. Resident #94 had to get out of bed, into his/her wheelchair to tell a nurse. 6. During an interview on 06/08/26, at 3:01 P.M., Resident #65 said aides often come to answer the call light, turn it off, say they will be back in a minute and never come back to the room. 7. During an interview on 06/08/26, at 3:18 P.M., Resident #61 said the following:-It could take an hour for a call light to be answered;-Aides come into the room, clear the call light, say they will be back and do not come back. 8. During an interview on 06/12/26, at 9:35 A.M., the Activity Assistant said any of the CNA's or nurses can answer call lights. During an interview on 06/12/26, at 1:55 P.M., CMT P said the following:-Anyone can answer a call light;-From what he/she was taught, anyone working in the building can answer the light to see what is needed and then get someone to help, if they cannot;-He/she did notice that a lot of staff just walked on past rooms with call lights on while he/she was busy. During an interview on 06/12/26, at 1:40 P.M., the Assistant Director of Nursing (ADON) B said the following:-Anyone working can answer a call light;-The responding staff may not be able to provide personal care, but they are able to help the resident by getting them drinks, a blanket, telling them what was on the (continued on next page)

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	day's menu or activity schedule or just giving them some kind of requested/needed information;-They should let nursing know right away and let the resident know that someone will be with them as soon as possible. During an interview on 06/12/26, at 2:20 P.M., the Administrator said the following:-Anyone working in the building can answer a call light at any time and is expected to do so;-He/she answers lights and has seen staff from all departments answering call lights. Complaints #2980701, #3015959, #3022401, and #3033613.

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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 - Some	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 residents were free of medication errors greater than 5% when staff failed to prime insulin pens (hormone to help regulate the amount of glucose (type of sugar) in the blood) prior to administration per manufacturer's administration instructions for three residents (Resident #10, #38, #97). Three medication errors occurred out of 26 opportunities resulting in an error rate of 11.54%. The facility census was 113.Review of the facility policy titled Medication Administration and General Guideline, dated January 2026, showed the following:-Medications are administered as prescribed;-Medication is administered in accordance with state regulations and using good nursing principles and practices;-Staff familiarize themselves with drug reference material provided by facility. Review of Humalog (rapid acting insulin) Kwik-Pen manufacturer's instructions titled Instructions for Use, instructions on priming the pen, revised 07/2025, showed the following:-Prime before each injection;-Priming the pen means removing the air from the needle and cartridge that may collect during normal use and ensures the pen is working properly;-If a person does not prime before each injection, he/she may get too much or too little insulin;-To prime the pen, turn the dose knob to select 2 units;-Hold the pen with the needle pointed up, tap the cartridge holder gently to collect air bubbles at the top;-Push the dose knob in until it stops and 0 is seen in the dose window;-Hold the dose knob in and count to 5 slowly;-Should see insulin at the tip of the needle. Review of the Novolog (rapid acting insulin) Flex-Pen manufacturer's instructions titled Patient Fact Sheet: How to Use Flex-Pen, instructions on priming the pen, revised 02/2023, showed the following:-Prior to each injection, turn the dose selector to 2 units;-Hold the Flex-Pen with the needle pointing upwards;-Tap the cartridge gently to make air bubble collect at the top of the cartridge;-Press the push button all with way in, the dose selector should return to 0;-A drop of insulin should appear at the needle tip. 1. Review of Resident #10's face sheet showed the following:-admit date of 10/29/25;-Diagnosis of diabetes (disease in which the body cannot regulate blood sugar levels). Review of the resident's care plan, last revised on 02/04/26, showed the following:-He/she had diabetes and wore an electronic monitor;-Monitor resident for signs of hypoglycemia / hyperglycemia (low /high blood sugar);-Provide diabetic medication as prescribed by provider. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 04/23/26, showed the following:-No cognitive impairment;-Required daily insulin injections. Review of the resident's current physician orders, reviewed 06/11/26, showed the following:-An order, dated 02/26/26, for Humalog injection, inject 6 units before meals;-Humalog injection given on a sliding scale based on blood glucose levels,-For blood glucose level of 70-149 milligrams/deciliter (mg/dL), give 0 units;- For blood glucose level of 150-200 mg/dL, give 2 units;- For blood glucose level of 201-250 mg/dL, give 4 units;- For blood glucose level of 251-300 mg/dL, give 6 units;- For blood glucose level of 301-350 mg/dL, give 8 units;- For blood glucose level of 351-400 mg/dL, give 10 units;-Notify physician when blood glucose levels less than 70 mg/dL or greater than 400 mg/dL. Observation on 06/10/26, at 11:58 A.M., showed the following:-Licensed Practical Nurse (LPN) L checked the resident's blood glucose level. It registered a level of 163 mg/dL. The LPN drew up 8 units of Humalog;-The nurse verified the order, identified the resident, and administered 8 units of Humalog insulin through a Humalog Kwik-Pen;-LPN L did not prime the insulin pen. 2. Review of Resident #38's face sheet showed the following:-admission date of 01/25/25;- Diagnosis of diabetes. Review of the resident's care plan, last revised on 02/03/26, showed the following:-He/she had diabetes and wore an electronic monitor, but often refused to wear it;-He/she was non-compliant with diet interventions;-Monitor resident for signs of hypoglycemia / hyperglycemia (low /high blood sugar);-Provide diabetic medication as prescribed by provider. Review of the resident's quarterly MDS, dated [DATE], showed the following:-No cognitive impairment;-Required daily insulin injections. (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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's current physician orders, current as of 06/11/26, showed the following:-An order, dated 04/22/26, for Novolog injection, given on a sliding scale based on blood sugar levels,- For blood glucose level of 141-180 mg/dL, give 1 unit;- For blood glucose level of 181-220 mg/dL, give 2 units;- For blood glucose level of 221-280 mg/dL, give 3 units;- For blood glucose level of 281-340 mg/dL, give 4 unit;,- For blood glucose level of 341-400 mg/dL, give 5 unit;.-Notify physician when blood glucose levels greater than 300 mg/dL. Observation on 06/10/26, at 11:20 A.M., showed the following:- LPN L checked the resident's blood glucose level. It registered high. The nurse called the on-call provider who gave an order to administer 5 units of Novolog insulin. The nurse drew up 5 units of Novolog insulin;-LPN L verified the order, identified the resident, and administered 5 units of Novolog insulin through a Novolog Flex-pen;-LPN L did not prime the insulin pen. 3. Review of Resident #97's face sheet showed the following;-admission date of 05/08/25;-Diagnosis of diabetes. Review of the resident's care plan, last revised on 03/13/26, showed the following:-He/she had diabetes;-Monitor resident for signs of hypoglycemia / hyperglycemia (low /high blood sugar);-Provide diabetic medication as prescribed by provider;-Educate on importance of medication compliance. Review of the resident's quarterly MDS, dated [DATE], showed the following:-No cognitive impairment;-Required daily insulin injections. Review of the resident's current physician orders, current as of 06/11/26, showed the following:-Humalog injection given on a sliding scale based on blood glucose levels;- For blood glucose level of 70-130 mg/dL, give 0 units,- For blood glucose level of 131-180 mg/dL, give 4 units;- For blood glucose level of 181-240 mg/dL, give 8 units;- For blood glucose level of 241-300 mg/dL, give 10 units;- For blood glucose level of 301-350 mg/dL, give 12 units;- For blood glucose level of 351-400 mg/dL, give 16 units;-Notify physician when blood sugar levels are less than 60 mg/dL or greater than 500 mg/dL. Observation on 06/10/26, at 12:10 P.M., showed the following:- LPN L checked the resident's blood glucose level. It registered as 321 mg/dL. The nurse drew up 12 units of Humalog;-LPN L verified the order, identified the resident, and administered 12 units of Humalog insulin through a Humalog Kwik-Pen;-LPN L did not prime the insulin pen. 4. During an interview on 06/10/26, at 12:45 P.M., LPN L said the following:-He/she was supposed to prime insulin pens before administering insulin;-Insulin pens are primed with 2 units;-Priming the insulin pen was important to ensure residents were getting the right dosage of insulin;-The facility had completed education on insulin administration. During an interview on 06/12/26, at 8:35 A.M., LPN O said the following:-Insulin pens should be primed with 1 to 2 units of insulin before administration;-It was important to ensure the air was out of the needle and it was filled to ensure the correct dose;-The facility had completed education with staff on medication administration. During an interview on 06/12/26, at 8:50 A.M., Registered Nurse (RN) N said the following:-Nursing staff should prime insulin pens with two units before administration;-Priming the pen was important to fill the needle and give the correct dose of insulin;-Staff should verify the order and the resident to ensure the correct medication is given. During an interview on 06/11/26, at 12:30 P.M., the Assistant Director of Nursing (ADON) said the following:-Staff were educated to prime insulin pens with 2 units before administration;-Priming the pen was important to ensure the correct dose was given;-He/she expected all staff to prime insulin pens before administering insulin. During an interview on 06/12/26, at 12:00 P.M., the Director of Nursing said she expected all nurses to prime insulin pens before administering insulin. During an interview on 06/11/26, at 8:20 A.M., the Medical Director said the following:-Best practice was to prime insulin pens before administration of insulin;-He expected nursing staff to be priming insulin pens before administration of insulin. During an interview on 06/12/26, at 2:00 P.M., the Administrator said she expected staff to follow manufacturer's guidelines and facility policy regarding medication pass and priming of insulin pens. Complaints #2988862 and #2992581

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 ensure residents were free from significant medication errors when staff failed to prime insulin pens (hormone to help regulate the amount of glucose (type of sugar) in the blood) prior to administration per manufacturer's administration instructions for three residents (Resident #10, #38, #97). Three medication errors occurred out of 26 opportunities resulting in an error rate of 11.54%. The facility census was 113.Review of the facility policy titled Medication Administration and General Guideline, dated January 2026, showed the following:-Medications are administered as prescribed;-Medication is administered in accordance with state regulations and using good nursing principles and practices;-Staff familiarize themselves with drug reference material provided by facility. Review of Humalog (rapid acting insulin) Kwik-Pen manufacturer's instructions titled Instructions for Use, instructions on priming the pen, revised 07/2025, showed the following:-Prime before each injection;-Priming the pen means removing the air from the needle and cartridge that may collect during normal use and ensures the pen is working properly;-If a person does not prime before each injection, he/she may get too much or too little insulin;-To prime the pen, turn the dose knob to select 2 units;-Hold the pen with the needle pointed up, tap the cartridge holder gently to collect air bubbles at the top;-Push the dose knob in until it stops and 0 is seen in the dose window;-Hold the dose knob in and count to 5 slowly;-Should see insulin at the tip of the needle. Review of the Novolog (rapid acting insulin) Flex-Pen manufacturer's instructions titled Patient Fact Sheet: How to Use Flex-Pen, instructions on priming the pen, revised 02/2023, showed the following:-Prior to each injection, turn the dose selector to 2 units;-Hold the Flex-Pen with the needle pointing upwards;-Tap the cartridge gently to make air bubble collect at the top of the cartridge;-Press the push button all with way in, the dose selector should return to 0;-A drop of insulin should appear at the needle tip. 1. Review of Resident #10's face sheet showed the following:-admit date of 10/29/25;-Diagnosis of diabetes (disease in which the body cannot regulate blood sugar levels). Review of the resident's care plan, last revised on 02/04/26, showed the following:-He/she had diabetes and wore an electronic monitor;-Monitor resident for signs of hypoglycemia / hyperglycemia (low /high blood sugar);-Provide diabetic medication as prescribed by provider. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 04/23/26, showed the following:-No cognitive impairment;-Required daily insulin injections. Review of the resident's current physician orders, reviewed 06/11/26, showed the following:-An order, dated 02/26/26, for Humalog injection, inject 6 units before meals;-Humalog injection given on a sliding scale based on blood glucose levels,-For blood glucose level of 70-149 milligrams/deciliter (mg/dL), give 0 units;- For blood glucose level of 150-200 mg/dL, give 2 units;- For blood glucose level of 201-250 mg/dL, give 4 units;- For blood glucose level of 251-300 mg/dL, give 6 units;- For blood glucose level of 301-350 mg/dL, give 8 units;- For blood glucose level of 351-400 mg/dL, give 10 units;-Notify physician when blood glucose levels less than 70 mg/dL or greater than 400 mg/dL. Observation on 06/10/26, at 11:58 A.M., showed the following:-Licensed Practical Nurse (LPN) L checked the resident's blood glucose level. It registered a level of 163 mg/dL. The LPN drew up 8 units of Humalog;-The nurse verified the order, identified the resident, and administered 8 units of Humalog insulin through a Humalog Kwik-Pen;-LPN L did not prime the insulin pen. 2. Review of Resident #38's face sheet showed the following:-admission date of 01/25/25;- Diagnosis of diabetes. Review of the resident's care plan, last revised on 02/03/26, showed the following:-He/she had diabetes and wore an electronic monitor, but often refused to wear it;-He/she was non-compliant with diet interventions;-Monitor resident for signs of hypoglycemia / hyperglycemia (low /high blood sugar);-Provide diabetic medication as prescribed by provider. Review of the resident's quarterly MDS, dated [DATE], showed the following:-No cognitive impairment;-Required daily insulin injections. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's current physician orders, current as of 06/11/26, showed the following:-An order, dated 04/22/26, for Novolog injection, given on a sliding scale based on blood sugar levels,- For blood glucose level of 141-180 mg/dL, give 1 unit;- For blood glucose level of 181-220 mg/dL, give 2 units;- For blood glucose level of 221-280 mg/dL, give 3 units;- For blood glucose level of 281-340 mg/dL, give 4 units;- For blood glucose level of 341-400 mg/dL, give 5 units;-Notify physician when blood glucose levels greater than 300 mg/dL. Observation on 06/10/26, at 11:20 A.M., showed the following:- LPN L checked the resident's blood glucose level. It registered high. The nurse called the on-call provider who gave an order to administer 5 units of Novolog insulin. The nurse drew up 5 units of Novolog insulin;-LPN L verified the order, identified the resident, and administered 5 units of Novolog insulin through a Novolog Flex-pen;-LPN L did not prime the insulin pen. 3. Review of Resident #97's face sheet showed the following;-admission date of 05/08/25;-Diagnosis of diabetes. Review of the resident's care plan, last revised on 03/13/26, showed the following:-He/she had diabetes;-Monitor resident for signs of hypoglycemia / hyperglycemia (low /high blood sugar);-Provide diabetic medication as prescribed by provider;-Educate on importance of medication compliance. Review of the resident's quarterly MDS, dated [DATE], showed the following:-No cognitive impairment;-Required daily insulin injections. Review of the resident's current physician orders, current as of 06/11/26, showed the following:-Humalog injection given on a sliding scale based on blood glucose levels;- For blood glucose level of 70-130 mg/dL, give 0 units,- For blood glucose level of 131-180 mg/dL, give 4 units;- For blood glucose level of 181-240 mg/dL, give 8 units;- For blood glucose level of 241-300 mg/dL, give 10 units;- For blood glucose level of 301-350 mg/dL, give 12 units;- For blood glucose level of 351-400 mg/dL, give 16 units;-Notify physician when blood sugar levels are less than 60 mg/dL or greater than 500 mg/dL. Observation on 06/10/26, at 12:10 P.M., showed the following:- LPN L checked the resident's blood glucose level. It registered as 321 mg/dL. The nurse drew up 12 units of Humalog;-LPN L verified the order, identified the resident, and administered 12 units of Humalog insulin through a Humalog Kwik-Pen;-LPN L did not prime the insulin pen. 4. During an interview on 06/10/26, at 12:45 P.M., LPN L said the following:-He/she was supposed to prime insulin pens before administering insulin;-Insulin pens are primed with 2 units;-Priming the insulin pen was important to ensure residents were getting the right dosage of insulin;-The facility had completed education on insulin administration. During an interview on 06/12/26, at 8:35 A.M., LPN O said the following:-Insulin pens should be primed with 1 to 2 units of insulin before administration;-It was important to ensure the air was out of the needle and it was filled to ensure the correct dose;-The facility had completed education with staff on medication administration. During an interview on 06/12/26, at 8:50 A.M., Registered Nurse (RN) N said the following:-Nursing staff should prime insulin pens with two units before administration;-Priming the pen was important to fill the needle and give the correct dose of insulin;-Staff should verify the order and the resident to ensure the correct medication is given. During an interview on 06/11/26, at 12:30 P.M., the Assistant Director of Nursing (ADON) said the following:-Staff were educated to prime insulin pens with 2 units before administration;-Priming the pen was important to ensure the correct dose was given;-He/she expected all staff to prime insulin pens before administering insulin. During an interview on 06/12/26, at 12:00 P.M., the Director of Nursing said she expected all nurses to prime insulin pens before administering insulin. During an interview on 06/11/26, at 8:20 A.M., the Medical Director said the following:-Best practice was to prime insulin pens before administration of insulin;-He expected nursing staff to be priming insulin pens before administration of insulin. During an interview on 06/12/26, at 2:00 P.M., the Administrator said she expected staff to follow manufacturer's guidelines and facility policy regarding medication pass and priming of insulin pens. Complaints #2988862 and #2992581

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, facility staff failed to maintain a complete infection prevention and control program when staff did not perform appropriate hand hygiene when providing personal care for three residents (Residents #112, #12, and #19). The facility census was 113. Review of the facility policy titled Standard Precautions, reviewed 10/25/22, showed the following: -The facility will use standard precautions which are the minimum infection prevention practices that apply to all resident care regardless of suspected or confirmed infection status of the resident; -These practices help protect the employees and residents from spreading infections; -Standard precautions include hand hygiene; -Perform hand hygiene before and after direct contact with residents or when hands are visibly soiled and after contact with blood, body fluids, secretions, excretions, patient's intact skin or wound dressings and contaminated items immediately after removing gloves and between patient contact; -Wear gloves when touching blood, body fluids, secretions, excretions, or contaminated items with mucus membranes and non-intact skin; -If hands move from a contaminated site to clean body site during care, wash hands or use hand sanitizer. Review of the facility's policy, dated 04/28/22, titled Hand Hygiene, showed the following: -The facility will provide guidelines to employees on proper handwashing and hand hygiene techniques that will aid in the prevention of the transmission of infections; -Employees will be trained and receive ongoing education on the importance of hand hygiene in preventing the transmission of healthcare-associated infections (HAI); -Hand hygiene should be performed before and after providing care; with contact with blood, body fluids, or contaminated surfaces; before and after applying and removing gloves; and after handling soiled linens and items potentially contaminated with blood, body fluids, or secretions; -Employees will perform handwashing with soap and water when hands are visibly soiled; -Employees may use an alcohol-based hand rub when hands are not visibly soiled. 1. Review of Resident #112's face sheet (admission information) showed the following: -admission date of 05/22/20; -Diagnoses included vascular dementia (decline in thinking and memory caused by reduced blood flow to the brain), seizures, and metabolic encephalopathy (brain dysfunction caused by chemical, hormonal, or systemic imbalances in the body). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's quarterly Minimum Data Set (MDS – a federally mandated assessment completed by facility staff), dated 06/03/26, showed the following: -Severely impaired cognition; -Required partial/moderate staff assistance with toileting hygiene and upper and lower body dressing; -Always incontinent of urine and frequently incontinent of bowel. Review of the resident's care plan, dated 02/13/26, showed the following: -Activities of Daily Living (ADLs) self care deficit because of dementia; -Required staff assistance for personal hygiene and dressing; -Mixed bladder incontinence related to dementia; -Clean perineal area with each incontinence episode. Observation on 06/09/26, at 6:18 A.M. showed the following: -Certified Nurse Aide (CNA) E assisted the resident to lay down on the bed to change his/her wet brief and do perineal care; -Without performing hand hygiene, the CNA put on gloves and removed the resident's incontinent brief which was wet with urine; -He/she used a wet wipe to cleanse the front perineal area; -He/she removed the gloves, did not perform hand hygiene, and donned new gloves; -He/she applied perineal wash with the wet wipe, turned the resident to his/her side, and wiped down between the buttocks, and then put a clean brief on the resident; -Without removing gloves or performing hand hygiene, the CNA assisted the resident to transfer to the wheelchair by holding the resident under one arm; -Without performing hand hygiene and changing gloves, the CNA changed the resident's shirt and then wheeled him/her out of the room to the dining room; -The CNA then removed his/her gloves and did not perform hand hygiene. 2. Review of Resident #19's face sheet showed the following: -admission date 11/13/19; -Diagnoses included chronic obstructive pulmonary disease (COPD - a lung disease that blocks the air flow and makes it difficult to breathe), major depression, anxiety, seizures, overactive bladder, high blood pressure, and Alzheimer's disease (memory, think and behavior affected that symptoms (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	eventually grow severe). Review of the resident's comprehensive MDS, dated [DATE], showed the following: -Moderately impaired cognition; -Used a wheelchair; -Required partial/moderate staff assistance with toileting hygiene; -Required substantial/maximum staff assistance for upper and lower body dressing and personal hygiene; -Always incontinent of urine and bowel. Review of the resident's care plan, dated 09/22/21, showed the following: -ADL self-care performance deficit related to dementia; -Set-up to extensive assistance with personal hygiene and can wash his/her face; -Extensive staff assist with toileting at times, typically continent during the day and incontinent during the night, and wears briefs. Observation on 06/09/26, at 6:58 A.M., showed the following: -CNA F went into the resident's room, washed hands, and put on gloves; -The CNA assisted the resident to transfer from the bed to the wheelchair; -The CNA took the resident to the bathroom and the resident stood and used the handrail as the CNA pulled down the resident's wet incontinence brief and placed it in the trash can; -Without performing hand hygiene or changing gloves, the CNA put a clean brief on the resident; -Without performing hand hygiene or changing gloves, the CNA put on the resident's shirt and pulled up the resident's pants; -Without performing hand hygiene or changing gloves, the CNA got the resident's toothbrush and asked the resident to brush his/her teeth; -Without performing hand hygiene or changing gloves, the CNA turned on the hot water, left the room, and returned with clean sheets and laid them on the resident's bedside table; -Without performing hand hygiene or changing gloves, the CNA wet a washcloth and handed it to the resident to wash his/her face; -The CNA removed his/her gloves and donned new gloves without performing hand hygiene; (continued on next page)

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	265477	A. Building B. Wing	06/12/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident asked the CNA for assistance to wash his/her hands and with the CNA's assistance moved over to wash hands at the sink; -Without performing hand hygiene or changing gloves, the CNA F brushed the resident's hair; -The CNA assisted the resident to the wheelchair, removed the trash bag from the bathroom, helped put the resident's shoes on, and then he/she picked up the bags on the floor, tied them, and removed gloves; -Without performing hand hygiene, he/she removed the trash to the shower room, and then he/she washed hands in shower room sink. 3. Review of Resident #12's face sheet (brief resident profile sheet) showed the following: -admission date of 11/26/25; -Diagnoses included schizoaffective disorder (mental health condition that includes features of both schizophrenia and a mood disorder), anoxic brain damage (an injury to the brain that caused brain cells to die due to a lack of oxygen), cellulitis (deep inflammation of the tissues just under the skin, caused by infection) of left lower limb, cognitive communication deficit (difficulty to understand language or to speak due to a thinking impairment), generalized muscle weakness, and need for assistance with personal care. Review of resident's comprehensive Minimum Data Set (MDS – a federally mandated assessment tool filled out by facility staff), dated 04/10/26, showed the following: -Moderate cognitive impairment; -Required substantial assistance from staff with toileting, personal hygiene, and eating; -Dependent on staff for transferring, repositioning, showering, and dressing; -Used manual wheelchair. Review of the resident's care plan, reviewed/revised on 04/30/26, showed the following: -The resident had an activities of daily living (ADL) deficit. The resident was incontinent of bowel and bladder and dependent on staff for personal hygiene; -The resident had impaired physical mobility and required transfer and repositioning assistance. Observation on 06/11/26, at 2:35 P.M., showed the following: -CNA M and CNA C entered the resident room, used hand sanitizer, and applied gloves; -CNA C brought a package of wipes, a brief, and barrier cream from the resident's bathroom and placed items on top of resident's bedside table; -Both aides positioned the resident and pulled down his/her pants; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-CNA M unhooked resident's wet brief, pulled it back, folded under the used brief, and pulled out a clean wipe to wash the front perineal area from front to back three separate times. The CNA placed the dirty wipes in the trash; -CNA C turned the resident on his/her left side while CNA M pulled out the used brief and placed it in the trash; -CNA M pulled out several clean wipes (without performing hand hygiene or changing gloves) and performed incontinent care; -Without performing hand hygiene or changing gloves, CNA M unfolded the clean brief and tucked it under the resident; -Without performing hand hygiene or changing gloves, CNA M squeezed tube of barrier cream onto his/her gloves and applied cream to the resident's; -Both aides repositioned the resident; -Without performing hand hygiene or changing gloves, CNA M pulled the clean brief into place and attached the tabs; -Without performing hand hygiene or changing gloves, CNA C and CNA M used the draw sheet to pull the resident up in bed. CNA C repositioned pillow under the resident's head and both aides placed another pillow under the lower legs, and put on protective boots; -CNA C and CNA M removed their gloves, placed them in the trash, and did not perform hand hygiene; -CNA C covered the resident with a sheet and blanket and placed the call light at his/her side; -CNA M moved the bedside table to the resident's right side. Then gathered the package of wipes and barrier cream to place inside resident's bathroom; -CNA C took out the trash liner from trash can, placed a new liner in trash can, and carried trash bag out of the resident's room; -The CNAs used hand sanitizer in the hallway. 4. During an interview on 06/11/26, at 2:46 P.M., CNA C said the following: -Staff should wash hands or use hand sanitizer before and after resident cares; -Should change gloves when going from a dirty area to a clean area; -Should wash hands or use hand sanitizer in between glove changes. During an interview on 06/11/26, at 2:50 P.M., CNA M said the following: -Staff should wash hands before entering the room, before putting on gloves, in between glove changes, and before providing care; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Staff should change gloves in between dirty to clean area cares. During an interview on 06/12/26, at 8:28 A.M., CNA F said the following: -They were to wash hands between glove changes, when they entered and left the room, after they took the resident to the bathroom, and when they made the resident's bed; -He/she did carry hand sanitizer. During an interview on 06/12/26, at 2:53 P.M., Certified Medication Technician (CMT) T said the following: -Staff were to wash hands between glove changes; -When staff went into a resident's room, they were to take off gloves and wash and/or sanitize their hands. During an interview on 06/12/26, at 12:16 P.M., Assistant Director of Nursing (ADON) B said the following: -Staff should wash hands if hands are soiled. Staff may use hand sanitizer or wash hands before and after resident care; -Staff should put on gloves for any direct care or items that could have contact with bodily fluids; -Should change gloves after going from a dirty area to a clean area; -Should perform hand hygiene before putting on gloves, in between glove changes, and after removing gloves. During an interview on 06/12/26, at 3:05 P.M., ADON A said the following: -Staff were to wash hands when they go into a resident's room and when they leave the room; -Staff were to wash hands before applying gloves, and after removing gloves. During an interview on 06/11/26, at 2:40 P.M., the Director of Nursing (DON) said the following: -The nurse aides do training that included hand hygiene; -Staff were to treat everyone as if they were on standard precautions; -Staff were to wash hands when they removed gloves; -Staff were not to walk down halls wearing the same gloves that they performed care with. During interviews on 06/12/26, at 3:15 P.M. and 5:15 P.M., the Administrator said the following: -She expected staff to wash hands and change gloves according to policy; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Staff were to wash hands when changing gloves, before going into a resident's room, before leaving a resident's room, and after removing gloves; -Staff were to wash hands when they removed their gloves during perineal care. Complaint #2980701