

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265477	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/08/2026
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)		
F 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them. Based on interview and record review, the facility failed to obtain a radiology services to meet the needs of all residents when staff failed to obtain an ordered x-ray in a timely manner for one resident (Resident #1) who complained of wrist pain. The facility's census was 107. Review showed the facility did not provide a policy regarding x-rays services. Review of the facility's policy, Physician's Orders, dated 09/28/22, showed the following:-Purpose to provide guidance and ensure physician's orders are transcribed and implemented in accordance with professional standards, state and federal guidelines;-Physician's order sheets (POS) will be maintained with current physician orders as new orders are received. Discontinued orders will be marked as discontinued with the date, and all new order will be written in the appropriate area on the POS with the date the order was received. 1. Review of Resident #1's face sheet (a document that gives a resident's information at a quick glance) showed the following:-admission date of 06/19/24;-Diagnoses included cognitive communication deficit (difficulty with thinking skills), guillain-barre syndrome (auto immune disorder where the immune system mistakenly attacks the nerves in the legs), pain, and panic disorder (episodes of fear with shortness of breath). Review of the resident's admission Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff), dated 06/01/26, showed the following information:-Cognitively intact;-Impairment on both sides;-Used a wheelchair for mobility;-Required supervision assistance with upper body dressing, toileting hygiene and personal hygiene;-Required partial assistance with showers, and lower body dressing. Review of the resident's nurse practitioner (NP) progress note, dated 06/29/26, showed the following:-Chief complaint of left wrist pain and edema (swelling) following brace removal;-Resident seen today at the request of staff for evaluation of left wrist pain and edema;-Resident is post a recent left wrist fracture and the orthopedic specialists had recently removed the stabilizing brace;-Resident reported active left wrist pain, currently managed with as needed analgesics (painkiller);-Left wrist edema noted with brace no longer in place. Wheelchair used for mobility;-Ordered left wrist x-ray today;-Instructed nursing to apply ice to the left wrist four times daily for swelling;-Continue current pain management regime. Review of the resident's June 2026 showed an order, dated 06/29/26, for a left wrist x-ray, one time only for three days; Review of the resident's June 2026 Medication Administration Record (MAR) showed on 06/29/26, at 4:01 P.M., LPN K signed off the left wrist x-ray was completed Review of the resident's record showed staff did not document regarding completion of the x-ray ordered, results, and physician notification of the x-ray delay Review of the resident's July 2026 POS showed an order, dated 07/07/26, for left wrist 2 view x ray, stat (immediately) one time only for pain for 3 days. During an interview on 07/07/26, at 1:15 P.M., the resident said the following:-His/her wrist had been hurting more the past two weeks;-His/her wrist was swollen, red, and bruised;-He/she rated his/her pain a 9 on a scale from 1 to 10;-He/she saw the NP on 06/29/26, and they ordered an x ray. The (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 265477 If continuation sheet Page 1 of 3

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F 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	x-ray had not been completed; -He/she saw the doctor on 07/06/26, and there was no x ray completed by then. During an interview on 07/08/26, at 10:45 A.M., Certified Medication Tech (CMT) I said when an x-ray is ordered, the nurse will add the order to the resident's Treatment Administration Record (TAR) and those orders were completed by nurses. During an interview on 07/08/26, at 12:41 P.M., LPN K said the following:-If the doctor orders an x ray, staff obtain what views are requested and put this order into the TAR;-The nurse calls the x-ray company and provides them the information on the x-ray, what views, which doctor ordered the x-ray, and the resident's room number;-The x-ray company provided an estimated timeframe of when their tech would be out;-On stat orders it's usually a couple of hours and on non stat orders, probably the next day;-All of the information is put into the resident's medical record;-The resident came to him/her about an x-ray and he/she asked Registered Nurse (RN) J. RN J said one was ordered and it was done on 07/07/26 (eight days after the original order.) During an interview on 07/28/26, at 12:51 P.M., RN L said the following:-When there is an order for an x-ray, staff place it in the medical record;-The nurse will call the x-ray company, print out the face sheet and the physician's order, and place them in the book;-If the x-ray is ordered stat, it's usually that day. If it's not stat, it's usually completed the following day; -If the x ray is not done the following day, he/she would call the x-ray company to see where the resident is at on the list;-The order is placed on the nurse's TAR and they mark it off as done, when it's done;-If it's placed on the TAR for a three day order, it will fall off after three days whether the x-ray was completed or not;-He/she was not aware of an order prior to the one for 07/07/26;-The resident got his/her x-ray done on 07/07/26. During an interview on 07/08/26, at 1:16 P.M., LPN M said the following:-When an x-ray is ordered by the doctor or NP, the floor nurse, NP, or doctor will put it into the medical record for the nurses to complete;-The nurse will call the x-ray company to give them the order, and the provide the necessary information;-If the order is stat, it normally takes less than two hours;-If the order is not stat, it takes two to four days. If it is not completed within the time frame, the staff will call 24 hours after to follow up;-The doctor or NP put in the order for the resident and it was placed for three days. If it's not completed, it will fall off. During an interview on 07/08/26, at 1:33 P.M., the Assistant Director of Nursing ADON (A) and ADON (B) said the following:-X-rays are put in the orders and nurses are responsible for putting them into the TAR;-The ADONs check the orders from the NP and doctor's daily and add them to the TAR;-When an x-ray is ordered, the nurse is responsible for calling x-ray company and providing them the information and then they print of the order and face sheet and place that in the book;-ADON B provided the book with multiple orders and it did not have any orders for the Resident;-When the x-ray company comes in to do the x-ray, they take the paperwork out of the book;-A non stat order is usually completed the same day, or the following day;-If the x-ray has not been completed in three days, he/she would expect staff to be calling the x-ray company to see when they will be coming;-They expected the staff to notify the doctor to see if they want the resident to be sent out;-The order is listed on the TAR, if it is not completed, and it's only on there for 3 days, it will fall off whether it's done or not;-They did not know the resident had an x-ray ordered on 06/29/26. It should not be marked off as completed if it was not completed. During an interview on 07/08/26, the Director of Nursing (DON) said the following:-When an x ray is ordered, the doctor or NP puts the order in the electronic medical record this pops up when the order is due and the nursing staff confirm the details and call x-ray company;-The nursing staff provide the x-ray company all of the necessary information and they print off the face sheet and order and this is put in the book for x-ray company when they arrive;-Sometimes a non stat order can take several days;-He/she would expect the staff to call the x-ray company if they have not shown up in two to three days;-The x-ray company did not complete the order for the resident's x ray on 06/29/26. (continued on next page)		

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F 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	He/she looked for the results and did not find them so an order was placed for stat x-ray. During an interview on 07/08/26, the Administrator said the following:-Nurses put orders for x-rays on the TAR in the electronic medical record;-The nurse will call the x-ray company and they are usually out in a reasonable time. If the order, if not stat it usually takes one day;-If the x-ray company did not show up, he/she would expect staff to follow up in three days with the x-ray company;-The staff print off the order and face sheet and this information is placed into the book;-The ADONs are responsible for ensuring the orders are completed;-He/she didn't know why it wasn't done and believed it was overlooked. Complaint #3067770		